

**Parental Consent and Liability Release Form**

PARTICIPANT'S NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

PARTICIPANT EMAIL (If applicable) \_\_\_\_\_

ADDRESS \_\_\_\_\_

PARTICIPANT CELL PHONE (If applicable) \_\_\_\_\_

PARENT NAME(S) \_\_\_\_\_

PARENT CELL PHONE(S) \_\_\_\_\_ / \_\_\_\_\_

PARENT BEST CONTACT EMAIL \_\_\_\_\_

TO WHOM IT MAY CONCERN:

The undersigned does hereby give permission for my child:

\_\_\_\_\_ ("Participant"), to attend and participate in the prospect baseball camp.

LIABILITY RELEASE: In consideration allowing the Participant to participate in camps and clinics, I, the undersigned, do hereby release, forever discharge and agree to hold its staff, camp directors, employees, volunteers and instructors from any and all liability, claims or demands for accidental personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the Participant while involved in camps and/or clinics. I the parent or legal guardian of this Participant hereby grant my permission for the Participant to participate fully in camp & clinic activities.

Furthermore, I, on behalf of my minor Participant, hereby assume all risk of accidental personal injury, sickness, death, damage and expense as a result of participation in recreation and work activities involved therein.

The undersigned further hereby agrees to hold harmless and indemnify any staff, camp directors, employees, volunteers, or instructors for any liability sustained as the result of the negligent, willful or intentional acts of said Participant, including expenses incurred attendant thereto.

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MEDICAL TREATMENT PERMISSION: I authorize an adult, in whose care the minor has been entrusted, to consent to any emergency x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital or emergency care facility. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child or youth pursuant to this authorization.

\_\_\_\_\_  
Name of participant                      Signature of participant                      Date

\_\_\_\_\_  
Name of parent (If minor)      Signature of parent (If minor)                      Date

Medical Insurance Company: _____ Phone: _____
Policy/Group ID#: _____ Policy Holder's Name: _____
Emergency Phone #s in case parent/guardian cannot be reached: _____
Parent Signature _____
Parent Printed Name _____ Date _____