GULF COAST TEXAS DIVISION COMPETITIONS

Fencer's Name: _____

Check One:

❒ I am an adult, 18 years or older, and agree to ---

❒ I am the Parent of the named minor (under 18 years of age) and agree to direct my child to --

Cooperate and to conform with directions and instructions of the Tournament Organizers, activity co-sponsors, and/or their representatives in charge of the tournament, with the rules and regulations of the facilities and the USFA, and all directions given by tournament officials and organizers, activity co-sponsors, and/or their representatives.

***WAIVER OF LIABILITY*: I understand that participation in any sporting activity carries a certain degree of risk for injury. Upon entering this tournament, I agree to abide by the current rules and safety regulations of the USFA, Tournament Organizers and Facilities Owners. Failure to follow these rules and regulations will result in expulsion and no refund of fees will be made. Expulsion is at the sole discretion of the Tournament Organizers or Bout Committee, and the decision may not be appealed. I enter this activity at my own risk and release the Tournament Organizers and Facilities, their Board of Directors, sponsors, and organizers from any liability. I understand that reasonable measures will be taken to safeguard the health and safety of the group.**

I have read and understand the forgoing statements and agree to assume the responsibility stated and waive all claims.

_____ _____

(Signature of Fencer) (Date) (Signature of Parent or Guardian of Minor) (Date)

CONSENT FOR MEDICAL TREATMENT

This is to certify that on this date I, _____, give my consent to the Tournament Local Organizer or their representative to obtain medical care from any licensed physician, hospital or clinic for the above named athlete for any injury or illness that may arise during this activity. **In the event of sickness or accidents, I will not hold the tournament organizer, facility administration or group sponsor responsible. In case of sickness or accident, I authorize the calling of a medical doctor and/or providing of other necessary medical services. I agree to pay for those medical services that are deemed necessary by medical authorities.**

_____ _____

(Signature of Fencer) (Date) (Signature of Parent or Guardian of Minor) (Date)

INSURANCE INFORMATION		
	Primary Insurance Information	Secondary Insurance Information
Name of Carrier		
Name of Policy Holder		
Address of Carrier		
Policy Number		