

# CMTC Border Bowl Waiver

## INFORMED CONSENT STATEMENT

Participation in any sports or recreational activities comes with inherent risk. There is a risk of injury associated with participation in any sports activity, as well as the use of CMTC sports and recreation facilities. It is the responsibility of each individual to have insurance coverage sufficient to provide for medical or dental services and/or equipment resulting from any injury sustained or incurred as a result of participating in the Border Bowl 7v7 Tournament.

Participation in this sports program activity is on a strictly voluntary basis. As a result, you should note and understand that CMTC Soccer Center, its employees, administration and volunteers, are not responsible for any injury that may occur to individuals participating in any recreational sports activities, including but not limited to the soccer field and that each participating individual fully assumes the risks associated with engaging in such activities.

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### ***Release of Liability and Medical Consent Form***

I hereby release and hold harmless from liability CMTC Soccer Center, its affiliates, staff members, volunteers, and other employee and/or agents in the event of any injury to my student not resulting from the negligence of any such staff, volunteers, and other employee and/or agents while my student is engaging in activities at Price Park Fields.

I further consent to any hospital or medical care necessary for my student, and such care as may be approved by my student's instructor and physicians immediately employed by any medical facility where they may be treated, including whatever emergency treatments in the judgment of said physicians may be considered necessary or advisable for my student/students.

I have read this Release of Liability and Medical Consent Form and fully understand its contents.

\_\_\_\_\_  
*Parent/Guardian signature*

\_\_\_\_\_  
*Student signature*

\_\_\_\_\_  
*Relationship*

\_\_\_\_\_  
*Date*

Please provide the following health insurance information for your student in case of necessity of medical treatment. If you have an HMO or PPO type plan that limits emergency providers, please attach the names of several approved emergency facilities on a separate sheet of paper.

\_\_\_\_\_  
*Insurance Company Name*

\_\_\_\_\_  
*Policy Number/Group number*

\_\_\_\_\_  
*Insured Name (parent/guardian)*

\_\_\_\_\_  
*Student's Identification Number*

\_\_\_\_\_  
*Known allergies or medical conditions*

***Emergency Contact Information. In case of a medical emergency please contact:***

\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Relationship to student*

\_\_\_\_\_  
*Contact Address*

\_\_\_\_\_  
*Contact Phone #*