

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER



PARTICIPANT'S NAME: _____
BIRTH DATE: _____
SEX: _____

PARENT/GUARDIAN'S NAME: _____
HOME ADDRESS: _____
HOME PHONE: _____
MOBILE PHONE: _____

I, (name of parent or guardian) _____, grant permission for my child (name of child) _____ to participate in _____, organized by European Paintball Federation (EPBF), which will be held in _____ on _____. This activity will take place under the guidance and direction of EPBF representatives.

A brief description of the activity follows:

Type of event or activity: Paintball tournament
Destination of event or activity: Av _____
Individual in charge or and responsible: _____
Estimated time of activity: _____

As parent, and/or legal guardian, I remain legally responsible for any personal actions taken by the above named young person ("participant").

I agree on behalf of myself, my child's other parent if known or living (name of parent) _____, my child named herein, to hold harmless and defend EPBF representatives, or representatives associated with the event with respect to any and all actions, claims or demands that may be made or brought against the EPBF representatives, or representatives associated with the event, arising from or in connection with my child's attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the EPBF representatives, or representative associated with the event for reasonable attorney's fees and expenses arising in connection therewith.

Signature _____ Date _____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, sign only those in accordance with your wishes:

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

NAME & RELATIONSHIP: _____ PHONE _____
FAMILY DOCTOR _____ PHONE _____
FAMILY HEALTH PLAN CARRIER: _____
POLICY NUMBER: _____

Signature _____ Date _____