QTS COACHING CLINIC
ATTENDANCE FORM

I would like to be included in the Q.T.S. Coaching Clinic at Belmont on.....
(to be completed by parent or guardian if under 18 years of age)

Name:.....

Address:.....

Date of Birth:..... Age:..... Male: Female:

Club:.....

Contact Number:.....

Email address:.....

I am a disabled shooter: YES NO

Disciplines you shoot	Last 3 scores	Disciplines you shoot	Last 3 scores
Prone I.S.S.F.		Prone Silhouettes	
3 Position I.S.S.F.		Target Silhouette Rifle	
Air Rifle I.S.S.F		T.R.A. Bench Rest	

Would you like to shoot another discipline than the one/s you presently shoot? If so, which one/s: ……...

Describe briefly what you would like to achieve through your participation at this camp?

.....

.....

What do you feel you need most help with regarding your shooting?

.....

.....

Do you have a coach? YES NO If yes, who is your coach?.....

Do you agree to be photographed for the purpose of coaching analysis and promotion in print or electronic form. YES NO

SIGNATURE: .....DATE:.....
(Parent or Guardian if under 18 years of age)**QUEENSLAND TARGET SPORTS INC. (QTS)**

QTS COACHING CLINIC

PARENT/GUARDIAN CONSENT FORM

I.....*(*Parent/Guardian of)

ATHLETE'S FULL NAME:.....

ADDRESS:…….....

Permit…….....to attend the QTS Coaching Clinic

at……**JIM SMITH RANGE, BELMONT**.....from…….……..to……..……..

I agree that *(Athletes name)*…….…….....shall be subject to the guidance of QTS Coaching Coordinator and/or Coaches during the period of the camp. In the event of any illness or accident I authorise the obtaining, on my behalf, of such medical assistance as required.

I accept all necessary medical attention required and the responsibility for payments of any expenses thus incurred.

QTS believes it is important that all possible care and welfare is considered for all members when attending training camp, therefore it is important that the Coordinator is informed of any special medical treatments, conditions or care that is required for the junior /athletes.

Special medical condition, treatment, allergies, ailments, medication and or care for the above mentioned athlete (If applicable):

……

……

……

MEDICARE No:…….....in the event that medical assistance is required for the above mentioned athlete.

Emergency contact details :

Parents/Guardian Names……..

Emergency Phone (day) ……..……(night) …….....

Mobile …….

Should the above mentioned athlete be part of any act of misconduct, I authorise the Coordinator to arrange for his/her immediate return to their home after first notifying me of the facts and I further agree to pay additional expenses which may be incurred as a result.

Signature by Parent/Guardian……..Date…….

Please return to: **QTS COACHING COORDINATOR**
P.O. Box 4133,
GUMDALE. Q. 4154

or email: coach@targetsports.org.au