

State Abbreviation: W I

Head Coach Last Name: Persinger



Scholastic Action Shooting Program 2025 Medical Consent Form



Team Name: Hudson Raider Shooting Club		
Athlete Name:		
Address: (no PO Boxes)		
City:	State:	Zip:

In the event that the Athlete may require emergency medical care, or in the event Athlete may become ill, while participating in the Scholastic Action Shooting Program, Athlete (and Athlete's parent/legal guardian if Athlete is a minor) hereby gives advanced consent to the Scholastic Shooting Sports Foundation, SASP Sponsors, and Governing Bodies, including their respective volunteers, to provide, through a medical staff of their choice, necessary or advisable medical care and treatment to Athlete.

Athlete (and Athlete's parent/legal guardian if Athlete is a minor) further agree to pay any and all medical costs, expenses and charges and to release, waive, discharge and hold harmless the Scholastic Shooting Sports Foundation, SASP Sponsors, Partners and the Governing Bodies, and each of their respective directors, officers, employees, agents or volunteers, from and against any liability or any claim or demand arising from or connected with such medical care and treatment.

I certify that I am not prohibited by Federal, State or Local law from possessing a handgun or ammunition. I do hereby give my consent and permission for this participant to temporarily possess handguns and ammunition while competing in Scholastic Action Shooting Program events and/or when traveling to or from such events. In the event that I cannot personally be present during competition or practice or travel to and from these events, I hereby appoint _____ to act as guardian in my stead.

Athlete Printed Name:	
Athlete Signature:	Date:
Parent / Legal Guardian Printed Name:	
Parent / Legal Guardian Signature:	Date:

Parent/Legal Guardian Information

Name:		Relationship To Athlete:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
E-mail Address:		

Athlete Email: _____ **Athlete Phone:** _____

In case a parent can't be reached, please list an **Emergency Contact Name:** _____ **Emergency Contact Phone:** _____

Please list any allergies or medical awareness needs: