State Abbreviation: ☐☐

Head Coach Last Name: _____

Scholastic Action Shooting Program

2017-18 Medical Consent Form

Team Name:		
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 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:**

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

! This form is to be retained by the Head Coach. DO NOT send this to Headquarters!