

Medical Release Form

Name of Minor: _____ Date: _____

The undersigned do hereby authorize the Shooting Director, Santa Lucia Sportsmen's Association, Inc. or the Director's designated agent, to act for the undersigned in matters related for consent to any X-ray, medical examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care required for the above minor, which is deemed advisable by and/or rendered, under the general or special supervision of any physician and surgeon, licensed under the Provision of Medicine Practice Act, or any dentist licensed under the Dental Practice Act where such diagnosis or treatment is rendered by the physician, surgeon, or dentist at an office, hospital or elsewhere.

Mother's Name: _____ (Printed) Father's Name: _____ (Printed)

Parent/Guardian Signature _____ Relationship: _____

Home Address: _____
 Street City State Zip

Mother's Home Phone: _____ Work Phone: _____

Father's Home Phone: _____ Work Phone: _____

Pager Number: _____ Cellular Phone: _____

"Shooting Sports Authorization for Shooter Under 18 Years of Age" (California Penal Code Section - 12552)

*Permission is granted for the above named minor to participate in the
BB Gun, Riflery, Shotgun, Black Powder and Archery Shooting Sports programs
at Santa Lucia Sportsmen's Association Range.*

Signature of Parent/Guardian: _____

Printed Name: _____ Relationship: _____

WITNESS SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ PHONE: _____