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|-----------|---------------|--------------|
| Last Name | First Name | MI |
| Address | City | State ZIP |
| Gender | Date of Birth | |

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|---------------|------------------|
| Father's Name | Home/Cell Number |
| Employer | Work Number |

| | |
|---------------|------------------|
| Mother's Name | Home/Cell Number |
| Employer | Work Number |

Are you a current member of the National Rifle Association or USA Shooting? Yes No

If yes, please provide membership number(s)

Have you had any previous shooting experience or training? Yes No

If yes, please list experience

Are either of your parents or guardians veterans of military service? Yes No

If yes, are they members of The American Legion? Yes No

I have read the above information and find it to be true to the best of my knowledge. I give permission for my son/daughter to become a member of this club and participate in the club activities.

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| Signature of applicant | Date |
|------------------------|------|

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| Signature of Parent(s)/Guardian(s) | Date |
|------------------------------------|------|



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|-----------|---------------|-------------------|-------|-----|
| Last Name | | First Name | | MI |
| Address | | City | State | ZIP |
| Gender | Date of Birth | Home / Cell Phone | | |

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|-------------------------------------------|--|------|-------|-----|
| Person to contact in case of an emergency | | | | |
| Address | | City | State | ZIP |
| Phone Number | | | | |

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|---------------------------|---------------|
| Medical Insurance Company | Policy Number |
|---------------------------|---------------|

Please check "YES" or "NO" and provide details where requested. All information will be kept CONFIDENTIAL.

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| Are you allergic to any medication (including aspirin, penicillin, sulfa, etc.)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| List any allergies you have | | |
| Do you take any prescribed medication on a permanent or semi-permanent basis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| List medications and give reason | | |
| Have you ever been told by a doctor that you have epilepsy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had an epileptic seizure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been treated for diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been told by a doctor that you were anemic? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been told by a doctor that you have sickle cell anemia? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have or have you had high blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have or have you ever had heart disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have or have you ever had lung disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



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| Do you have or have you ever had kidney disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have or have you ever had liver disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever been told by a doctor that you have asthma? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had a hernia or "rupture"? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has it been repaired? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever been "knocked out" (unconscious) in the past three years? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| List dates | |
| Have you had a concussion or other head injury in the past three years? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| List dates | |
| Have you been hospitalized overnight due to a head injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| List dates | |
| Is there any special accommodations needed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please list | |
| | |

The information above is correct to the best of my knowledge.

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|---------------------|------|
| Signature of member | Date |
|---------------------|------|

*** If the member is under 18 years of age, a parent or legal guardian must also sign.**

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|------------------------------------|------|
| Signature of Parent(s)/Guardian(s) | Date |
|------------------------------------|------|



Participant Name

If I am injured or suffer illness or disease while participating in the programs of the _____ Post 109 Junior Shooting Sports Club except as may be caused by the gross negligence or reckless conduct of the Shooting Club, I and my parent(s) or guardian(s) waive any legal claim against the _____ Post 109 Junior Shooting Sports Club and its affiliating American Legion Post. If injured while traveling to or from any _____ Post 109 Junior Shooting Sports Club activity by public, private or any other means of conveyance, I agree to waive any legal claims against the _____ Post 109 Junior Shooting Sports Club, its leaders and its sponsors.

I give consent for the _____ Post 109 Junior Shooting Sports Club to provide medical attention, transportation, and emergency medical services as warranted by the circumstances. (The club sponsor may require a guarantee of medical, doctor, or hospital bills.)

I state that I am in good physical condition and I am not aware of any disease or injury that would be aggravated or result in my being incapacitated or injured during any program participation.

I further understand and agree to abide by the general rules of conduct prescribed for the members of the _____ Post 109 Junior Shooting Sports Club and that violations may result in denial of privileges and a forfeiture of all fees paid.

I have read this release. I understand that it affects my legal rights and responsibilities, and I hereby agree to its terms and conditions.

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|---------------------|------|
| Signature of member | Date |
|---------------------|------|

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| Signature of Parent(s)/Guardian(s) | Date |
|------------------------------------|------|

For club members under 18, parent(s) or guardian(s) must sign the statement below:

I have explained to my son/daughter the aforementioned stipulated conditions and their ramifications and I further consent to his/her membership in the Post 109 Junior Shooting Sports Club

. As his/her parent/guardian, I understand the terms of this release and hereby waive any claim(s) as set forth herein.

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|------------------------------------|------|
| Signature of Parent(s)/Guardian(s) | Date |
|------------------------------------|------|