Licking County 4-H Shooting Sports
PERMISSION TO PARTICIPATE & HEALTH FORM

Please mark projects you are taking:
__Archery __ Pistol
__Hunting/Wildlife __ Rifle
__ Living History __ Shotgun
__ Muzzle loading

This form must be completed for each participant by the parents/guardians.
This information will be kept confidential and used only for the welfare of the participant. PLEASE PRINT!

GENERAL PARTICIPANT INFORMATION

Name ____
(Last) (First) (Middle)

Address ____
(Street) (City) (State) (Zip)

Please Mark: __Male __ Female Date of Birth ____________________________ Age ________

Main contact phone number: (will be used in case of cancellations, rescheduling, etc) ______________________________

Please Mark: __Home Phone __Parent's Cell Phone __Member's Cell Phone Is texting on this phone ok? __Yes __No

EMERGENCY CONTACT INFORMATION

Parent Name ______________________________________ Alternate Person ___________________________________
Phone ______________________________________ Phone______________________________________
Mobile Phone __________________________________ Mobile Phone __________________________________
Other Phone___________________________________ Other Phone __________________________________

MEDICAL AND ALLERGIC CONDITIONS: List any conditions which you would like volunteers to be aware of, for the safety of your child. Include chronic health conditions and allergies, including bee sting allergies, food allergies, etc.

Conditions: ____
Medications: ____
Specify any restrictions in activities: ____

PERMISSION & LIABILITY RELEASE
I understand that my child is not required to participate in this activity, but grant permission for him/her to do so, despite the possible risks. I recognize that by participating in this activity, as with any activity involving motor vehicle transportation, firearm and/or archery equipment use, and interaction with unfamiliar surroundings, my child may risk personal injury. I hereby attest and verify that I have been advised of the potential risks, that I have full knowledge of the risks involved in this activity, and that I assume any expenses that may be incurred in the event of an accident, illness, or other incapacity, regardless of whether I have authorized such expenses.

I agree to and do hereby, waive any and all claims against, and agree to fully release and hold harmless, the participating organizations, including Ohio State University, Licking County 4-H, the Johnstown Sportsmans Club, and 4-H Camp Ohio these organizations' officers, employees, agents and volunteers from any and all claims related to any illness, injury, and/or property damage which may arise from my child/ward's participation.

MEDICAL RELEASE
I understand that in the case of serious illness or injury, I will be notified. If I cannot be contacted, I give my permission to the attending physician to hospitalize, secure proper treatment and to order injection, anesthesia, or surgery for the participant listed. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Parent/Guardian Name____ (Print Please)

Parent/Guardian Signature_________________________________Date_____________

Participant Signature_____________________________________Date_____________