



Cedar Sport Shooting Club, Inc.

Membership Application

Name: _____

Address: _____

Age: _____ Birth Date: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

School Attended: _____

Current Grade in School: _____

Parent/Guardian: _____

Parent E-Mail Address: _____

*Application and permission to participate in activities
conducted by CSSC, Inc. and its affiliates are subject to the current membership
Rules and Regulations.*

Applicant Signature: _____

Parent Signature: _____

Sponsoring Members: 1. _____

2. _____

Recommendation by Member #1:

Recommendation by Member #2:

Recommendation of Membership Committee:

Admit? Yes _____ No _____ Date: _____

Approval of Club President: _____

Approval of CSSC President: _____

CEDAR SPORT SHOOTING CLUB, INC.

PERSONAL HEALTH AND MEDICAL HISTORY

(To be filled out annually by all participants)

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name _____ Date of birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

Business address _____ City _____ State _____ Zip _____

If person named above is not available in the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes No Explain: _____

GENERAL INFORMATION:	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

List any **medications taken** by participant including drug, dosage, route (oral, injection, etc.) and frequency:

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

Immunizations: (Give date of last inoculation.)

Tetanus toxoid _____ Measles _____ Polio _____

OR DPT _____ OR MMR _____

Hepatitis A _____ Varicella _____ OR Chicken pox _____

Hepatitis B _____

I give permission for full participation in CSSC, Inc. programs, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date _____ Signature of parent/guardian or adult _____

Date updated _____ Signature of parent/guardian or adult _____

Date updated _____ Signature of parent/guardian or adult _____