State Abbreviation: W I

Head Coach Last Name: Persinger

Scholastic Clay Target Program
2026 Medical Consent Form

Team Name: Hudson Raider Shooting Club		
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 Clay Target Program, Athlete (and Athlete's parent/legal guardian if Athlete is a minor) hereby gives advanced consent to the Scholastic Shooting Sports Foundation, SCTP® Sponsors, Partners 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, SCTP® Sponsors, Partners 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.

Athlete Printed Name:	
Athlete Signature:	**Date:**
Parent / Legal Guardian Printed Name:	
Parent / Legal Guardian Signature:	**Date:**

Parent/Legal Guardian Information

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

Athlete email: _____ **Athlete Phone:** _____

In case a parent can't be reached, please list an Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Please list any allergies or medical awareness needs:

This from is to be retained by the Head Coach.