



# Cedar Sport Shooting Club, Inc.

## Membership Application

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_

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 it's 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: \_\_\_\_\_

<b>GENERAL INFORMATION:</b>	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 \_\_\_\_\_