

Parental Medical Treatment Authorization

I, _____, am a parent or legal guardian of the minor child/children set forth below (hereinafter referred to collectively as "child").

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone No. _____

Relationship to the child: _____

MEDICAL CONSENT:

In case of an emergency, I authorize the PSC staff, volunteers, or authorized personnel to seek medical treatment for my child. I understand that all reasonable attempts will be made to contact me before such action is taken. I agree to assume all financial responsibility for any medical care provided.

This authorization shall remain in full force and effect until revoked in writing and sent by certified mail to PSC Shooting Club, Inc., PO Box 528, Friendswood, TX 77549-0528.

Parent's Signature

Parent's Printed Name

_____/_____/_____
Date

Child/Children:

Child's Name (Please print)

Child's Date of Birth

Child's Name (Please print)

Child's Date of Birth

Child's Name (Please print)

Child's Date of Birth

Child's Name (Please print)

Child's Date of Birth