

**LOS ANGELES RIFLE & REVOLVER JUNIOR CLUB  
ONE DAY AUTHORIZATION AND CONSENT FORM**

There will be a charge

Please fill out on computer, print out and sign. Otherwise, print plainly in ink.

Date: \_\_\_\_\_

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

Minor's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No. \_\_\_\_\_ Cell Phone No.: \_\_\_\_\_ Email: \_\_\_\_\_

Minor's Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

I, the parent/legal guardian of \_\_\_\_\_  
do hereby give permission to the Los Angeles Rifle & Revolver Junior Club and its instructors to furnish a rifle and ammunition to said minor for the purpose of instructing him/her in the safe handling of firearms and safe shooting.

All ammunition must be supplied by the parents or legal guardian.

I do further agree to indemnify and save harmless the Los Angeles Rifle & Revolver Junior Club, its instructors and all officers and employees thereof, from all suits or actions brought for, or on account of any injuries or damages received or sustained by any person or persons by or from the consequences of any negligence or any act or omission of the above named minor occurring during the course of said Instruction.

Dated: \_\_\_\_\_

Signed: \_\_\_\_\_

Parent-Legal Guardian

**AUTHORIZATION TO CONSENT TO TREAT A MINOR**

We the undersigned parent/legal guardian of \_\_\_\_\_, a minor, do hereby authorize the Los Angeles Rifle & Revolver Junior Club, 1300 Loma Aye., South El Monte, CA 91733 as agents for the undersigned to consent to and to provide any first aid as required, including paramedics and ambulance as well as any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agents(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable; and neither said agent or any organization involved assumes any financial responsibility for exercising this action.

This authorization is given pursuant to the provisions of Sections 25.8 of the Civil Code of California.

Name of Insurance Company: \_\_\_\_\_ Policy No. \_\_\_\_\_

Doctors Name: \_\_\_\_\_ Doctors Phone Number: \_\_\_\_\_

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

Special Medical and/or Psychiatric information of minor (use other page if needed):

Dated: \_\_\_\_\_

Parents' Signature: \_\_\_\_\_