MEDICAL TREATMENT INFORMATION

It is required that this information be on file at the camp in case of an emergency.
No participation will be allowed if the Medical Treatment Information is not provided.

Name: _____ Birthdate: ___/____/____

Mother's Name: _____

Day Phone: _____Cell Phone: _____

Father's Name: _____

Day Phone: _____Cell Phone: _____

Relative or friend to contact in case of an emergency (other than parent or guardian):

Name: _____Relationship: _____

Day Phone: _____

Health Insurance Company: _____

Policy Number: _____

Family Doctor: _____Phone: _____

Has participant had any serious illness or surgery? Yes / No If yes, describe nature and date:

_____

_____

Does participant have any medical problems which may interfere with camp activities? Yes / No If yes, give brief explanation:

_____

_____

ASSUMPTION OF RISK

The undersigned hereby acknowledges that he/she knowingly and voluntarily assumes all risks of bodily injury to his/her child, as stated, and expressly acknowledges their intention, by executing this instrument, to exempt and relieve the Tustin Unified School District (District), its officers, agents and employees, from any liability for personal injury, bodily injury, property damage or wrongful death that may arise out of or in any way be connected with the above-described activity. I have read the foregoing and have voluntarily signed this agreement. I am aware of the potential risks involved in this activity and I am fully aware of the legal consequences of signing this instrument. I further acknowledge that the District does not provide liability insurance for this program, nor does the District provide medical coverage for participants in the activity.

AUTHORIZATION TO TREAT A MINOR

I (We) the undersigned parent(s)/legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any emergency general hospital holding a current license to operate a hospital from the State of California Department of Public Health. 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 to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Signature of Parent or Guardian: _____ Date: _____

Student's Signature: _____ Date: _____

***Note: Please complete a separate Registration & Medical Form for each Dancer.