

**Tustin High School Dance Team and All-Male Audition
Medical Release**

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

Student Name: _____ Birth Date: ____/____/____
Mother's Name: _____ Day Phone: (____)_____
Father's Name: _____ Day Phone: (____)_____
Name of Relative or Friend to contact in case of emergency (other than a parent or guardian):
_____ Day Phone: (____)_____
Health Insurance Company: _____ Policy Number: _____
Family Doctor: _____ Phone: (____)_____
Have you had any SERIOUS illness or surgery? YES * ____ NO ____

*If YES, describe the nature and date of the illness or surgery: _____

Do you have any medical problems which may interfere with dance activities? YES * ____ NO ____

*If YES, describe the problem or limitation: _____

Will you have medication and/or an inhaler with you? YES * ____ NO ____

*If YES, what type of medication? _____

ASSUMPTION OF RISK - The below signed 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, 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 this activity.

Print Student Name

AUTHORIZATION TO TREAT A MINOR - I (WE) the undersigned parent(s)/legal guardian of _____, a minor, do hereby authorize and consent to an 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 judgement 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.

WE HAVE READ AND FULLY UNDERSTAND THE INFORMATION OUTLINED ABOVE AND AGREE TO COMPLY WITH ALL RESPONSIBILITIES.

Dancer's Signature

Date

Parent/Guardian Signature

Date