ACWLAX Medical Form

Participant Name: _____ Date of Birth:_____

Home Address: _____ Home Phone #:_____

In the event of an emergency, please contact:

Name: _____ Phone #:_____ Relationship:_____

Medical Information:

Please describe any medical conditions that might interfere with your full participation in the Academy (i.e. diabetes, asthma)_____

_____

Please list any allergies (i.e. food, insect, drug, etc.). _____

Please list any medications you are currently taking. _____

Insurance Information:

Policy Holder: _____ Policy #: _____

Insurance Company Name:

_____

Insurance Company Phone Number: _____

Release:

I, the parent/guardian of _____ (the "Participant"), hereby certify that the Participant is in good health and has no physical or other conditions that affect Participant's ability to fully participate in ACWLAX CLINIC and have not been advised otherwise by a medical practitioner. I understand that there is a risk of injury to the Participant as a result of her participation, and I knowingly and voluntarily assume all risk of such injury. I authorize emergency medical treatment deemed necessary by medical personnel if Participant is not able to act on her own behalf. I hereby waive and release ACWLAX and staff from any liability for any injury or illness incurred while at the Clinic. I will be financially responsible for any medical attention needed during the Program or resulting from an injury received at the Clinic. My medical insurance coverage shall be the insurance coverage for any medical treatment.

BY SIGNING BELOW, I HAVE READ AND UNDERSTAND THIS RELEASE AND I HAVE VOLUNTARILY SIGNED IT. I AGREE THIS RELEASE IS NOT ONLY BINDING ON ME BUT WILL ALSO BE BINDING UPON MY PERSONAL REPRESENTATIVES, EXECUTORS, HEIRS, AND ASSIGNS.

Parent/Guardian Name:
Parent/Guardian Signature: Date: