

PDA USA Day Camp 2012

MEDICAL INFORMATION AND AUTHORIZATION FOR MEDICAL TREATMENT

Gymnast information:

FIRST NAME: _____ LAST NAME: _____ AGE: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: (____) _____ EVE PHONE: (____) _____

PARENT'S E-MAIL: _____

Insurance Information

MEDICAL INSURANCE COMPANY: _____

POLICY #: _____ NAME OF POLICY HOLDER: _____

PROFESSION OF POLICY HOLDER: _____

POLICY HOLDER'S SS #: _____

Medical History: Known Allergies (drugs, etc.) and/or pre-existing conditions

Prescription Medication: _____

IN CASE OF EMERGENCY PLEASE CONTACT:

Primary: _____ Secondary: _____

NAME: _____ NAME: _____

DAY PHONE: _____ DAY PHONE: _____

EVE PHONE: _____ EVE PHONE: _____

RELATIONSHIP: _____ RELATIONSHIP: _____

CHECK ONE:

- | | | | |
|------------------------------------|--|------------------------------------|--|
| <input type="checkbox"/> 6/18-6/22 | <input type="checkbox"/> Full Days
<input type="checkbox"/> Half Days
<input type="checkbox"/> Single Days _____ | <input type="checkbox"/> 7/23-7/27 | <input type="checkbox"/> Full Days
<input type="checkbox"/> Half Days
<input type="checkbox"/> Single Days _____ |
| <input type="checkbox"/> 6/25-6/29 | <input type="checkbox"/> Full Days
<input type="checkbox"/> Half Days
<input type="checkbox"/> Single Days _____ | <input type="checkbox"/> 7/30-8/3 | <input type="checkbox"/> Full Days
<input type="checkbox"/> Half Days
<input type="checkbox"/> Single Days _____ |
| <input type="checkbox"/> 7/16-7/20 | <input type="checkbox"/> Full Days
<input type="checkbox"/> Half Days
<input type="checkbox"/> Single Days _____ | <input type="checkbox"/> 8/6-8/10 | <input type="checkbox"/> Full Days
<input type="checkbox"/> Half Days
<input type="checkbox"/> Single Days _____ |

PDA USA Gymnastics (Pacific Diving Academy USA) group insurance is "SECONDARY EXCESS COVERAGE" over any valid collectable coverage provided by the parents' separate of the employees' dependant group insurance.

PDA USA Gymnastics (Pacific Diving Academy USA) secondary excess accident medical insurance coverage has a \$100 deductible which PDA USA Gymnastics (Pacific Diving Academy USA) DOES NOT PAY in event of a mishap.

Release of Liability Waiver

Name of child participant (if under 18): _____

Name of adult participant/ parent: _____

I,(we) despite all the reasonable precautions implemented for safety, am (are) fully aware of and appreciate the risk, including the risk of catastrophic injury, paralysis and even death, as well as other damages and losses associated with participation in the programs or activities. I (we) knowingly and willingly assume all such risks. Consequently, I (we) hereby for myself, heirs, executors and administrators, do waive and release any and all rights and claims for damages against owner, operators, coaches and other members of PDA USA Gymnastics (Pacific Diving Academy USA) (the releases) and Arnold Elementary School, Cypress School District, its officers, teachers and employees from personal injury or accident of any sort or nature suffered by me (us), the undersigned, by reason of participation or membership in classes, lessons or any programs or activities of PDA USA Gymnastics (Pacific Diving Academy USA).

Adult participant/ parent or participant signature (if over 18) _____ Date _____

PDA USA AUTHORIZATION TO TREAT A MINOR (Pacific Diving Academy)

I (we), the undersigned parents, parents, or legal guardians 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 provision of the Dental Practice Act and on the staff of any acute 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 treatment of the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

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

List any restrictions: _____

Date: _____ Signature of father, mother, or legal guardian _____