Registration Form – Athlete Information

Athlete's Last Name First Name Middle Initial Gender Date of Birth

Mailing Address

City State Zip Code Home Phone #

Mother/ Guardian Name Mother's Work # Mother's Cell #

Father/ Guardian Name Father's Work # Father's Cell #

E-mail Address Emergency Contact #

Allergies to Food or Drugs, Special Medications, and/or Pertinent Information

Family Physician Physician Phone #

Insurance Provider and Policy #

How did you hear about us? ___Word of Mouth ____Flyer ____Birthday Party ___Other

If "Word of Mouth," who were you referred by?: _____

THE NAMED CHILD HAS MY PERMISSION TO ATTEND SO CAL TTC PROGRAM. I CONFIRM THAT HE/ SHE IS IN GOOD MEDICAL HEALTH. I 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 INDER THE PROVISIONS OF THE MEDICINE PRACTICE ACT OR A DENTIST 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 OF HOSPITAL CARE WHICH THE AFOREMENTIONED PHYSICIAN IN THE EXERCISE OF HIS BEST JUDGMENT MAY DEEM ADVISABLE. IT IS UNDERSTOOD THAT THE TREATMENT WILL NOT BE WITHHELD IF THE UNDERSIGNED CANNOT BE REACHED. I UNDERSTAND THE RISKS INVOLVED WITH ACROBATIC MOVEMENT AND AGREE TO HOLD HARMLESS SO CAL TTC, ITS PROGRAMS AND THEIR EMPLOYEES AND CONTRACTORS IN THE EVENT OF INJURY OR DEATH. THIS AUTHORIZATION IS GIVEN PURSUANT TO THE PROVISIONS OF SECTION 25.8 OF THE CALIFORNIA CIVIL CODE.

I agree to make full term payment until I have notified So Cal TTC in writing of my intentions to cancel.

PARENT SIGNATURE PRINT NAME DATE