

TVC VOLLEYBALL CLINICS

REGISTRATION

Trailblazervolleyballclub.com

SPORTS REGISTRATION & EMERGENCY FORM

CHILD'S NAME _____ AGE _____

PARENT/GUARDIAN NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE: Home _____ Cell _____ Emergency _____

E-MAIL _____

INSURANCE COMPANY _____ POLICY # _____

FOR OFFICE USE ONLY: Check # _____ Amount \$ _____ Date Rec'd _____

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 a 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.

List any restrictions or special needs we should be aware of: _____

Parent/Guardian Signature

Date

Venmo @TVCvolleyball
or
Checks made payable to TVC