
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 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 Yellow Pages Birthday Party Other

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

THE NAMED CHILD HAS MY PERMISSION TO ATTEND BOUNCE CALIFORNIA PROGRAM.
I CONFIRM THAT HE/SHE IS IN GOOD 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 UNDER 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 BOUNCE CALIFORNIA, 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 Bounce California in writing of my intentions to cancel.

Signature Date
PARENT SIGNATURE PRINT NAME DATE