Sangrock Taekwondo Medical Wavier!

Please turn in this completed form on the first day of After School /camp at the check in area.

Drop Off/Pick Up Location:_____

Child's Last Name, First Name:_____

School Currently Attending:_____

Parent/Guardian Name:_____

Street Address:_____

City State & Zip:_____

Email:_____

Home Phone:_____

Program Rules:
1. I will only leave the program with an adult that I know.
2. I will respect fellow children and teachers.
3. I will participate in all of the activities to the best of my ability.
4. I will act in a safe and responsible manner.
5. I will have fun!

I have read the rules and I will abide by these rules. I understand that the Sangrock staff has the right to remove any personfrom the program that does not abide by these rules. If I am asked to leave, I understand that my tuition is nonrefundable.

_____ _____
Child Signature/Date Parent Signature/Date

Alternate Pick-up Authorization:
I authorize the following individuals to pick up my child from the program.

_____
Name Relationship Phone Number

_____
Name Relationship Phone Number

☐ By checking box, I authorize my child to walk home from the program.

_____
Parent / Guardian Date

Photography Release:
I authorize Sangrock to obtain, store and or use without payment any photographs, slides and or videotapes of my child for public relations, marketing/advertising and or internal training purposes.

_____
Parent / Guardian Date

Physician's Order for Prescribed Oral Medication
All medication must be delivered by and in the original container in which it was dispensed and administered by a pre-authorized individual designated by the parent/guardian. No member of Sangrock is permitted to administer medication.
I have arranged, and hereby authorize the administration of prescribed medication for my child to be handled as follows:

_____ _____
Name of Medication Dosage

_____ _____
Name of Authorized Individual to Administer Medication Date & Times of Administration

_____ _____
Name of Issuing Physician Issuing Physician Emergency Phone Number

Significant side effects / adverse reactions that should be reported to physician: _____

_____ _____
Issuing Physician Signature Date Parent/Guardian Signature Date

Emergency Medical Information: _____

Child's Last Name, First Name

Allergies to food / medication: _____

Activity restrictions or precautions: _____

List any medication child is currently taking: _____

List any special needs or important information about your child's medical history/behavior: _____

_____

Please list at least two alternative individuals who may be contacted if your child should become ill and need to be sent home:

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

Emergency Medical Consent:
In the event that reasonable attempts to contact me and the two alternate individuals that I have designated a the phone numbers that I have provided on this form have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the physician, dentist and or hospital as applicable listed below:

_____

Preferred Physician Phone Number

_____

Preferred Dentist Phone Number

_____

Preferred Hospital Phone Number

In the event that the designated preferred physician, dentist and or hospital as applicable is not available, I hereby give my consent for the administration of any treatment deemed necessary by another licensed physician or dentist at any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

_____

Parent / Guardian Signature Date

Emergency Medical Refusal (do not complete if consent was given above)
I do not give my consent for emergency medical treatment of my child. IN the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

_____

_____

_____

Parent / Guardian Signature Date

Liability Waiver (must be signed in order for child to participate in the program)

I am the parent/legal guardian of_____. On behalf of myself and child, and our respective heirs, we acknowledge and agree that there is a risk of serious injury an or loss associated with child's participation in the Sangrock Summer Camp Program. As a condition of child's participation, we assume that risk and forever waive and agree to hold Sangrock Black Belt World and its shareholders, directors, officers, instructors, employees and agents harmless from any and all claims, liabilities and or damages arising out of child's participation in the program. I understand that child will not be permitted to participate in the program without signing this agreement.

_____

Parent / Guardian Date