# SAN DIEGO CIRCUS CENTER MEDICAL RELEASE FORM

PARTICIPANT'S NAME :

NAME OF PARENT OR GUARDIAN :

ADDRESS :

HOME PHONE : WORK PHONE :

CELL PHONE OR OTHER METHOD OF CONTACT :

EMAIL :

EMERGENCY CONTACT PERSON : RELATIONSHIP :

EMERGENCY CONTACT PHONE :

## CURRENT HEALTH

Please circle/list any condition or injury you have or have had in the past that might impact your ability to participate in any strenuous activities including, but not limited to the following conditions:

| | | | |
|---|---|---|---|
| Broken bones | Severe sprains | Seizures | Other |
| Heart condition | Diabetes or hyperglycemia | Spinal injury | |
| Asthma | Dislocation of joints | Allergic reactions | |
| Head injury or concussion | Panic or anxiety attacks | Strained or ripped tendons or ligaments | |
| Impaired vision | Hearing impairment | | |

Details :

## HEALTH INSURANCE INFORMATION

PRIMARY CARE DOCTOR : PHONE :

INSURANCE CO. NAME : POLICY # :

PREFERRED HOSPITAL :

PRESCRIPTION MEDICATION (IF ANY) : DOSAGE : TIME :

By signing below you give permission, in the event of any illness, injury or other emergency, to whatever x-ray, examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care from a licensed physician and/or surgeon as deemed necessary by the trainers present at the class or workshop for the safety and welfare of the program participant.

Special Notes:

SIGNED BY :

DATE :