To whom it may concern: I, the undersigned, being the parent, legal guardian or legal next-of-kin of:

____

(PRINT – Full Name of Student)

hereby authorize necessary medical treatment for this person while participating in the <u>Third Annual CIPA Spin Fest</u>. I also guarantee payment of all charges incurred during the treatment (e.g., ambulance, physician, hospital, x-ray, labs, drugs, etc.).

In regard to person, I submit the following information:

1. Height ____________ Weight __________

   Age ________ Date of Birth ____________

2. ALLERGIES (foods, medications, etc.): ____________________________________

   ____

3. Special Medical Problems: ____

   ____

4. Is participant currently under medical care? YES NO

If YES, describe nature of illness and treatment: ________________________________

____

5. Does participant carry medication on person? YES NO

If Yes, Name of Medication & Purpose: ______________________________

____

6. Date of Last Tetanus: ______________

7. Family Physician/Clinic: ______________________________

Address: ______________________________

City: ______________ Phone: ______________

8. Home Address: ______________________________

City: ______________ State: ________ Zip: ________

9. Emergency Contact #1 (Name & Relationship): ______________________

Cell Phone: ______________ Home Phone: ______________

10. Emergency Contact #2 (Name & Relationship): ______________________

Cell Phone: ______________ Home Phone: ______________

Participant's Name (Print): ______________________________

Participant Signature: ______________________________

Parent/Guardian Signature: ______________________________

(If participant is under 18)