

MANNA'S MARTIAL ARTS

ENROLLMENT APPLICATION Part 3 of 3



PARTICIPANT

NAME: _____
First Last

E-MAIL: _____

HOME PHONE: (_____) _____
Age

Keep on file for all programs until notified

REQUESTED AGE SPECIFIC PROGRAM

- | | |
|---|---|
| <input type="checkbox"/> Tiny Tigers (Ages 3 & 4) | <input type="checkbox"/> Try It Program |
| <input type="checkbox"/> Little Dragon (Ages 5 & 6) | <input type="checkbox"/> Birthday Party |
| <input type="checkbox"/> Dragon (Ages 7 through 11) | <input type="checkbox"/> After School Program |
| <input type="checkbox"/> Teen/Adult (Ages 12 to 29) | <input type="checkbox"/> Summer Activity Camp |
| <input type="checkbox"/> Songin (Minimum age 30) | <input type="checkbox"/> Outreach Program at: _____ |
| <input type="checkbox"/> Kickboxing (Min. Ages 12) | <input type="checkbox"/> _____ |

MANNA'S MEMBER #: _____

Consent To Treatment of Minor

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

The undersigned parent or guardian of _____ a minor, does hereby authorize, Manna's Martial Arts employee as agent(s) for the undersigned to consent to any X-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general, other care giving, medical treatment or special supervision of any physician and or surgeon licensed under the provision of the Medical Practice Act whether such diagnosis or treatment is rendered at the doctor's office or at the hospital or on location.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent (s) to give specific consent to any and all such diagnosis, treatment or hospital care which a physician, meeting the requirements of this authorization may, in the exercise of his/her best judgement deem advisable. Neither said agent or any organization involved assumes any financial responsibility for exercising this action.

(I) (We) hereby authorize any hospital which has provided treatment to the above named minor pursuant to the provisions of Section 25.8 of the Civil Code or succive code thereto of California to surrender physical custody of such minor to (my) (our) above named agent(s) upon completion of treatment. This authorization is given pursuant to Section 1238 of the Health and Safety Code or succive code thereto of California.

These authorizations shall remain effective until (month) ___(Day) ___ 20___ OR ___ until further notice

Initial here: Signature (Parent/Legal Guardian) _____ Date: _____

_____ Parents address and phone number _____

_____ Allergies: _____

_____ Medications Currently Taking: _____

Insurance Company: _____ Card copy attached yes no

Group # or ID # _____

Physician _____ Phone #: _____

Other information: _____

_____ Parent or Guardian _____ Date