**THE PERFECT PERFORMANCE**

**Medical Release Form**

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| **Participant Information** | |  |
| Participant Name: |  | |
| Address: | Home Phone: | |
|  | Cell Phone: | |
|  | Email: | |
|  | Birthday: | |
| **Parent/ Guardian Information** |  | |
| Name: |  | |
| Address: | Home Phone: | |
|  | Cell Phone: | |
|  | Email: | |

I, the Parent/Guardian listed above (“I”, “me”, or “my”), do herby give my permission to The Perfect Performance, LLC (“Perfect Performance”) and its representatives to secure medical attention for my child in the event of accident or illness while under Perfect Performance’s supervision. I understand that an adult representative of Perfect Performance will attempt to contact me before releasing my child to the care of a doctor or hospital.

Should my child need medical attention, and I cannot be contacted, neither Perfect Performance, nor its representatives shall be held responsible for any occurrence which might transpire during the rendering of medical services to my child by a doctor or hospital staff to whom my child may have been released.

It is further understood that the case of accident or illness which requires medical care, that I will assume the payment of all expenses incurred in securing the services of such medical care.

I further acknowledge that the reverse side of this document contains confidential information which I have supplied regarding my child’s medical status.

This information is to be shared with an attending physician and/or hospital staff member only in the case of emergency.

**I ATTEST THAT THE INFORMATION I HAVE GIVEN PERFECT PERFORMANCE IS TRUE AND CORRECT:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Signature of legal parent or guardian of the Participant Date***

**In the event of an emergency and you cannot be reached, please list two other persons we should call in an attempt to find you.**

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| --- | --- | --- |
| **Emergency Contact #1** | |  |
| Name: |  | |
| Home Phone: | Work Phone: | |
| Cell Phone: | Other: | |
| **Emergency Contact #2** | |  |
| Name: |  | |
| Policy Number | Phone: | |
| Cell Phone: | Other: | |

In the event of an emergency, and I cannot be reached, by executing this document, I hereby authorize the school district’s designated representative to take whatever action is deemed necessary and appropriate, including giving consent from medical treatment for the above named child (§35.01 Texas Family Code).

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| **Insurance Company** | |  |
| Name: |  | |
| Home Phone: | Work Phone: | |
| Medication | |  |

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| --- |
| I hereby give permission for my child to be given the below medications only as prescribed: |
| Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Is your child allergic to any medication, food, insects, or plants? YES \_\_\_\_\_ NO \_\_\_\_\_

If “YES” please list any allergies your child has to medication, food, insects, plants, etc.

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Please give any information about your child’s physical or medical conditions that you feel would be important in the case of emergency.

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