

EMERGENCY INFORMATION

and

MEDICAL CONSENT

NAME \_\_\_\_\_

In event of a medical emergency please contact:

(Full name) \_\_\_\_\_

(Address) \_\_\_\_\_

(Telephone number(s)) \_\_\_\_\_

(Relationship) \_\_\_\_\_

MEDICAL PLAN (if applicable):

(Name) \_\_\_\_\_

(Plan Number) \_\_\_\_\_ (Group Number) \_\_\_\_\_

PERSONAL PHYSICIAN (if applicable):

(Name) \_\_\_\_\_

(Address) \_\_\_\_\_

(Telephone) \_\_\_\_\_

I hereby give my consent to receive emergency medical treatment in the event that I am injured while I am a participant in an acrobatics workshop sponsored by Richie Gaona, and to permit Richie Gaona or his representative to arrange for any such treatment which is reasonably necessary in the event of such injury. I hereby agree to be responsible for the cost of all emergency services, including all medical treatment, which I receive in the event of such injury.

I certify that I am at least 18 years of age.

(Signature) \_\_\_\_\_ (Date) \_\_\_\_\_

(Printed Name) \_\_\_\_\_