

ORANGE COUNTY CHILDREN' S THEATRE

PERMISSION SLIP/MEDICAL RELEASE FORM/ WAIVER OF LIABILITY INDEMNIFICATION

I, the undersigned parent or legal guardian of _____ a minor, requests that he/she be permitted to participate with Orange County Children's Theatre. I have been advised of the rules, regulations, and expectations of the theater and agree to abide by them and to fulfill our obligations as required. If I have any questions regarding participation in this event I will ask a member of the Administrative Board of OCCT immediately and not wait for a problem to arise.

I will permit photographs and videos of my child taken at this event to be used for publicity and other purposes by authorization of the Administrative Board of OCCT.

Furthermore, I hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. 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 to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatments will not be withheld if the undersigned cannot be reached.

In consideration of acceptance of my child's registration for this activity, I hereby agree to indemnify and hold harmless Orange County Children's Theatre, its officers, administrative board, trustees, employees, and volunteers from any liability, claim, or action for damages resulting from, or in any way arising out of the participation in the activity listed above by my child. This authorization is to remain in effect during the time of enrollment in the activity listed above unless revoked in writing.

Parent's or Legal Guardian's Signature

Date

Phone _____

Physician _____

Physician's Phone

Insurance Plan

Please describe any medications being taken by cast member or state "NONE":

Date of last tetanus shot _____ / _____ / _____ Allergies _____

Emergency Contact _____ Phone # _____

Cell Phone # _____ Email address _____