Consent for Medical Treatment Adult (18 and over) Performer/Volunteer/Guest

Name _____ DOB _____

Address _____

_____

E-mail address _____

Emergency contact _____ Phone _____ Relationship _____

Family contact: _____ Phone _____ Relationship: _____

Doctor _____ Phone _____

Existing Medical Conditions _____

Medications _____

Allergies _____

Insurance company _____

Policy # _____

Whereas, I knowingly acknowledge that I am responsible for carrying medical insurance for myself and I acknowledge that I am responsible for any and all medical costs not covered by medical insurance, and if I choose to not carry medical insurance, I understand that it is my responsibility to pay all treatment costs in the event of an injury or illness while traveling, performing, or volunteering with the Wenatchee Youth Circus, Inc. I understand that the Wenatchee Youth Circus will seek out proper medical care for me in the event of an accident or illness or other injury and, therefore, I desire to grant any physician or surgeon who may be requested to render medical aid to myself the absolute authority to exercise his/her personal judgment regarding my care and while traveling, performing or volunteering with the Wenatchee Youth Circus. I give my consent and authorization for any surgical procedure, which may, in the opinion of the treating physician or surgeon, be required to be performed upon myself by reason of any illness or injury. Furthermore, I specifically consent to the administration of anesthesia and to all forms of medical care and treatment including the administration of drugs which are, in the opinion of the treating physician or surgeon, required for the proper medical treatment and to hold any physician or surgeon or medical treatment facility who may render such treatment, the Wenatchee Youth Circus Inc., and any of its representatives, free and harmless for any claim, demands, or suits for damages from any injury or complication whatsoever, including death, which may result from any accident, illness or treatment administered to the above mentioned person.

Dated this _____ day of _____ 20_____

_____

Name

State of_____

County of _____

On this day, _____, personally appeared before me, _____,

and made it known to me to be individual(s) described above.

Given under my hand and official seal this _____day of _____, 20_____.

_____

Notary Public in and for the state of Washington

Residing in_____

Expires_____

Updated 1/8/2018 by JRT