

LA City Open Water Junior Lifeguard Registration / Medical Authorization Form

DIRECTIONS: Please fill out this form completely and legibly in print. Be sure to read each section before filling in the corresponding part.

GENERAL INFORMATION

JUNIOR GUARD:

Name: _____ Age: _____ DOB: _____

Street: _____ Unit #: _____

City: _____ State: _____ Zip Code: _____

Gender: (Circle one) Male / Female Eyes: _____ Hair: _____ Height: _____ Weight: _____

Name of authorizing Parent or Guardian:

Print Name: _____ Date: _____

Signature: _____

The classes and programs in this brochure may be subject to cancellation

OFFICE USE ONLY

Uniform Issued: _____ Shorts: _____ Shirt: _____ Suit: _____

Division: AA (16-17) A (14-15) B (12-13) C (9-11)

Driver's License #: _____ Exp: ____/____/____

Receipt #: _____ Paid On: ____/____/____

Receipt #: _____ Paid On: ____/____/____

Swim Test: _____ Min _____ Sec. Initials: _____

Swim Test: _____ Min _____ Sec. Initials: _____

Swim Test: _____ Min _____ Sec. Initials: _____

PRESS AND PHOTO RELEASE

I understand that my child may be photographed/video taped while participating in the City of Los Angeles's Junior Lifeguard Program. I understand that these images will be used by the program for promotional purposes. These materials are the sole property of the City of Los Angeles and there will be no compensation for their use.

Name of authorizing Parent or Guardian:

Print Name: _____ Date: _____

Signature: _____

PARENT AGREEMENT FOR FIELD TRIP

To the Hansen Dam Aquatic Center / Cabrillo Beach Staff: I, _____ grant permission for my son/daughter to participate in the following field trip(s) to: _____ Parent/Guardian Name

- Local & regional competitions
- Beach trips
- Other various trips to be announced

All persons participating in the field trip(s) are deemed to have waived all claims against the Department of Recreation and parks and it's employees for injury, accident, illness, or death occurring during or by reason of the field trip. I agree to direct my child to cooperate and conform to department policies and directions and instructions of Recreation and Parks Personnel in charge of the activity.

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I, THE UNDERSIGNED, PARENT OF _____, A MINOR, DO HEREBY AUTHORIZE THE CITY OF LOS ANGELES DEPARTMENT OF RECREATION & PARKS OR ONE OF HIS EMPLOYEES, AS AGENTS FOR THE UNDERSIGNED, TO CONSENT TO ANY X-RAY EXAMINATION, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSIS OR TREATMENT AND HOSPITAL CARE WHICH IS DEEMED ADVISABLE BY, AND IS TO BE RENDERED UNDER THE GENERAL OR SPECIAL SUPERVISION OF, ANY PHYSICIAN AND SURGEON LICENSED UNDER THE PROVISIONS OF THE MEDICAL PRACTICE ACT ON THE MEDICAL STAFF OF ANY HOSPITAL, WHETHER SUCH DIAGNOSIS OR TREATMENT IS RENDERED AT THE OFFICE OF THE PHYSICIAN OR AT THE HOSPITAL.

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 TO THE ABOVE DESCRIBED 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.

THIS AUTHORIZATION IS GIVEN PURSUANT TO THE PROVISIONS OF FAMILY CODE SECTION 6910. I HEREBY AUTHORIZE ANY HOSPITAL WHICH HAS PROVIDED TREATMENT TO THE ABOVE NAMED MINOR PURSUANT TO THE PROVISIONS OF FAMILY CODE SECTION 6910 TO SURRENDER PHYSICAL CUSTODY OF SUCH MINOR TO (MY) (OUR) ABOVE-NAMED AGENT (S) UPON THE COMPLETION OF TREATMENT. THIS AUTHORIZATION IS GIVEN PURSUANT TO HEALTH AND SAFETY CODE SECTION 1283.

THESE AUTHORIZATIONS SHALL REMAIN EFFECTIVE UNTIL DECEMBER 31 OF THE CURRENT YEAR UNLESS REVOKED IN WRITING BY ME AND DELIVERED TO SAID AGENT (S) NOTED ABOVE.

DATED: _____

++SIGNATURE OF PARENT/LEGAL GUARDIAN: _____

PERSONAL HISTORY

PARTICIPANT'S NAME _____ DOB: ____/____/____

ADDRESS _____ CITY _____ ZIP _____

MOTHER'S HOME PHONE _____ WORK PHONE _____

FATHER'S HOME PHONE _____ WORK PHONE _____

ADDITIONAL PHONES (cellular, pager, etc.) _____

RELATIVE/FRIEND NAME AND PHONE _____

INSURANCE PLAN _____ POLICY _____

FAMILY DOCTOR _____ PHONE _____

ADDRESS _____ CITY _____

PARTICIPANT'S MEDICAL HISTORY _____

ALLERGIES _____

MEDICATIONS _____