

**MEDICAL RELEASE FORM TO PARTICIPATE IN  
THE 2012 CALIFORNIA STATE CONFERENCE  
(Please Print or complete using Adobe Acrobat Reader)**

I, \_\_\_\_\_ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child \_\_\_\_\_ (Child's Full Name) in the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the full responsibility for the payment of any and all expenses incurred in connection with such treatment. I will not hold the California State Society, N.S.C.A.R. responsible for any injury or harm sustained by my child/ward. This release is effective at State Conference, February 10-12, 2012.

**PARENT/GUARDIAN'S ADDRESS:**

\_\_\_\_\_ **Street Address**

\_\_\_\_\_ **City State ZIP + 4**

**HOME PHONE:** (\_\_\_\_\_) \_\_\_\_\_ **WORK PHONE:** (\_\_\_\_\_) \_\_\_\_\_

**NAME OF HEALTH INSURANCE HOLDER:** \_\_\_\_\_

**INSURANCE COMPANY:** \_\_\_\_\_

**INSURANCE MEMBERSHP NUMBER:** \_\_\_\_\_ **GROUP NUMBER:** \_\_\_\_\_

**NAME OF PERSONAL PHYSICIAN:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
Street City State ZIP +4

**TELEPHONE:** (\_\_\_\_\_) \_\_\_\_\_

**DOES YOUR CHILD HAVE A PRE-EXISTING MEDICAL CONDITION? IF SO, DESCRIBE BELOW.**

<b>DOES YOUR CHILD WEAR CONTACTS:</b>	<b>YES</b>	<b>NO</b>
<b>TYPES OF LENS</b>	<b>SOFT</b>	<b>HARD</b>
	<b>DAILY WEAR</b>	<b>EXTENDED WEAR</b>

**NAME OF DOCTOR:** \_\_\_\_\_

**TELEPHONE:** (\_\_\_\_\_) \_\_\_\_\_

**NAME OF DENTIST:** \_\_\_\_\_

**TELEPHONE:** (\_\_\_\_\_) \_\_\_\_\_

**NAME OF ORTHODONTIST:** \_\_\_\_\_

**TELEPHONE:** (\_\_\_\_\_) \_\_\_\_\_

**KNOWN ALLERGIES, CONDITIONS, SPECIAL NEEDS AND ANY MEDICATION(S) BEING TAKEN:**

*In case I cannot be reached, any of the following persons are designated to act on my behalf:*

**CONSENT FOR MEDICAL TREATMENT:**

As the parent/legal guardian of the above named child, I hereby give my consent for emergency medical care prescribed by a duly licensed hospital, Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent.

\_\_\_\_\_  
**Signature (Parent/Guardian)**

\_\_\_\_\_  
**Date**

Please provide a copy of your insurance card (both front and back)

**NO EXCEPTIONS!!!! NO FORM—NO TOUR!!!! This is for ALL C.A.R. Members participating in State Conference including those traveling with a parent/guardian and those who are of legal age.**