Family Name_____

ORANGE COAST MUSICAL ARTS (OCMA)
Parental Consent and Release Form for Participants in Concerts, Practices, Rehearsals, Tours or other Events

My child (children) **NAMES LISTED BELOW** has/have permission to participate in concerts, rehearsals, tours, or other events sponsored by OCMA. I (we) acknowledge that students are responsible for travel arrangements to and from all activity locations and parents and/or legal guardians are responsible for their supervision and safety at all times. I(we) understand that some of these activities are held at locations such as fairgrounds, adult day health centers, schools, churches, parade routes, shopping centers and similar locations where there may be hazards associated with, but not limited to, vehicular traffic, obstacles, heavy or sharp objects, slippery surfaces and injury from contact with other individuals. In the event of any injury to my child, I (we) hereby discharge, release and hold OCMA and its members, agents, officers and employees harmless from liability for damage or claims for damage for personal injury, including accidental death, as well as from claims for property damage which may be incurred by the undersigned and/or the name child (children) participant. As the undersigned parent or guardian I(we) hereby assume all risk of personal injury, sickness, death, damage and expense as a result of this participant's participation in all recurring and non-recurring concerts, practices, rehearsals, tours or other events.

I (we) understand that participation in OCMA and its concerts, tours, and activities is voluntary and at our election and choice, OCMA is a not-for-profit corporation and that its board of directors are volunteers and serve without compensation.

Each person signing below acknowledges having read this release and understands all its terms and their significance, and states that this release is signed and delivered voluntarily.

I understand that this authorization may be photocopied.

_____	_____
Student Name	Student Name
_____	_____
Student Name	Student Name
_____	_____
Student Name	Student Name
_____	_____
Parent/Guardian* Date	Parent/Guardian* Date

*If custody of the child has been awarded to one parent by a court of law, only custodial parent need sign

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is give to provide authority and power on the part of said agent(s) to give specific consent to any and all diagnosis, treatment or hospital care which such physician or dentist in the exercise of his/her best judgment may deem advisable. This authorization is given pursuant to the provisions of Section 6910 of the California Family Code and shall remain effective until revoked.

CHECK ONE

☐ I/we hereby authorize OCMA to engage for my/our child/children at my/our expense any necessary emergency medical or dental care, until I/we can be informed and can make further arrangements. In this connection, I/we hereby incorporate by reference to "Authorization to Consent to Treatment of a Minor" set forth above.

☐ I/we expressly withhold such authorization.

Family Name_____

Medical Emergency Release Information

EMERGENCY MEDICAL AND DENTAL TREATMENT

While your child is participating in an OCMA activity, an accident or emergency illness may occur which requires immediate attention without sufficient time to contact a parent or legal guardian. The California Legislature has authorized consent in advance by parents or legal guardian for such treatment (Section 6910 of the California Family Code). Below we afford you the opportunity to choose whether the authorization permitted by that statute shall or shall not be given respecting your child.

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I(we) hereby authorize OCMA's representative or such substitute as he/she may designate from time to time as our agent(s) to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment or 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 or to consent to an X-Ray examination, anesthetic, dental or surgical diagnosis or treatment or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, hospital or otherwise.

Family Physician_____
Name City Phone Number

Family Insurance Carrier_____Policy Number_____

1. _____ _____ _____
Student Name Birth Date Date of Last Tetanus Shot

Is the Student taking Medication? ☐ No ☐ Yes _____
Specify & Dosage

_____ _____
Restricted or Allergic to: FOODS Restricted or Allergic to: MEDICINES

2. _____ _____ _____
Student Name Birth Date Date of Last Tetanus Shot

Is the Student taking Medication? ☐ No ☐ Yes _____
Specify & Dosage

_____ _____
Restricted or Allergic to: FOODS Restricted or Allergic to: MEDICINES

3. _____ _____ _____
Student Name Birth Date Date of Last Tetanus Shot

Is the Student taking Medication? ☐ No ☐ Yes _____
Specify & Dosage

_____ _____
Restricted or Allergic to: FOODS Restricted or Allergic to: MEDICINES

_____ _____ _____
First Person We Should Contact (PRINT PLEASE) Cell or Pager Phone Number Home Phone Number

_____ _____ _____
Second Person We Should Contact (PRINT PLEASE) Cell or Pager Phone Number Home Phone Number

X_____ _____
Parent or Legal Guardian's Signature **Date Signed**

Rev. 8/13/15