Insurance Form

LAST NAME_____FIRST_____DATE OF BIRTH_____

LAST NAME_____FIRST_____DATE OF BIRTH_____

ADDRESS_____

HOME PHONE_____WORK PHONE_____

PARENTS LAST/FIRST NAMES_____

MEDICAL INSURANCE NAME_____POLICY NUMBER_____

We the undersigned understand that this camp is held in furthering the education and social needs of the Zartoshti community in California. All the organizers and helpers are voluntary members. They do not assume any individual responsibility in material as well as injury to the participants. All the participants are participating at their own risk and as in part members who run this camp. We will be available to cater to any emergency or accident to our youth during the camp period.

Authorization to consent to treatment and responsibility of payment

I (we), parents of the above youth do hereby authorize the organizer as agent for the undersigned to consent to 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 specific supervision of, any physician or surgeon licensed under the provision of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at office of said physician or at said hospital. This permission includes any necessary dental agreement to be performed by a licensed dentist under provision of the Dental Practice Act.

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 on part of aforesaid agents to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. This authorization is given pursuant to the provisions of the Civil Code. This authorization shall remain effective until revoked sooner in writing, delivered to the said agents.

In consideration of the benefits to be derived from the aforesaid outing(s) I (we) hereby voluntarily waive any claim against California Zoroastrian Center and the volunteers arranging this camp.

It is understood that a conscientious effort will be made to contact you the undersigned prior to rendering treatment, but in order to safeguard the well-being, any of the above will not be withheld.

I (we) waive all claims against California Zoroastrian Center and the volunteers arranging this camp during attendance of such event. I (we) the undersigned, being parent(s) of above named youth(s) do hereby give my (our) consent and permission for my (our) child to attend said activities.

I (we) are responsible for 'all' medical/dental expenses of my (our) youth being sent to camp.

PHYSICIAN (personal): Name/Address/Phone_____

SIGNED BY:

Father_____Mother_____

Date_____

(Please note any special instruction to physician or nurse concerning any physical restriction)