

## 2009-2010 MEDICAL TREATMENT RELEASE FORM

State of Nevada)

)ss.

County of Clark)

I, \_\_\_\_\_ do hereby grant permission for my child \_\_\_\_\_, to travel and participate in competitions, exhibitions, practices, tours, and/or activities with Flip For Me Gymnastics, their staff, or assistants. I also not only grant permission for, but encourage, and necessary emergency medical treatment that may be required due to injury during these activities.

I fully understand and agree to maintain and uphold up-to-date primary health medical insurance on my child during the entire time he/she is enrolled at Flip For Me Gymnastics.

### MEDICAL CONDITIONS THAT WE NEED TO BE AWARE

Of \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
HOME TELEPHONE NUMBER

\_\_\_\_\_  
CELL PHONE NUMBER

\_\_\_\_\_  
WORK TELEPHONE NUMBER  
(Mother and/or Father)

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Notary Public \_\_\_\_\_

Expiration Date \_\_\_\_\_

Person to contact in if unable to reach parent (s):

\_\_\_\_\_  
Name

\_\_\_\_\_  
Telephone Number