Channel Islands Chrysalis Community
Medical/Liability Release

I do hereby authorize and consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment rendered under the general or special supervision of any member of the medical staff and emergency staff licensed under the provisions of the Medicine Practice Act, or a dentist licensed under the provisions of the Dental Practice Act, or the staff of any acute general hospital holding a current license from the State of California, Department of Public Health, to operate a hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but it is given to provide authority and power to render care which the aforementioned Physician, in the exercise of his best judgement, may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of the State of California. I (We) do forever release, acquit, discharge, and covenant to hold harmless the Channel Islands Chrysalis Community, their affiliated organizations, directors, staff, volunteers and guests from any and all actions, causes of action, claims, demands, costs, loss of services, expenses and compensation, on account of, or in any way growing out of, any and all known and unknown personal injuries and property damage which may occur as a result of participation in this program. This consent shall remain in effect indefinitely unless otherwise specified.

TO BE COMPLETED BY PARENT OR GUARDIAN (if applicant is under 18):

_____ has my/our permission to attend the Chrysalis program. In the event of emergency, my authorization for emergency treatment is provided above.

SIGNATURES:

_____/_____ Date _____
Participant's Signature Print Name

_____/_____ Date _____
Parent or Guardian Signature Print Name
(if applicant is under 18)

In the event that the above named participant must return home before the program is over, or in case of a medical emergency, please provide the telephone number(s) where an emergency contact may be reached.

Emergency Contact Person(s) Name: _____

Phone #(s): (_____)_____-_____ (_____)_____-_____

Please list any allergies, medications being taken, medical problems, special diet, or other pertinent information or restrictions:

_____

_____

_____

PLEASE MAIL TO:

Daniel Faina
Registrar
5990 Fearing Street
Simi Valley, CA 93063
www.cichrysalis.org

Phone:
(805) 527-3428
registrar@
cichrysalis.org