



**2010 Female ACL Injury Prevention Summer Program Enrollment Form**

**Preferred Location:**    **South**    **Central**    **Round Rock**

**Participant Information**

<b>Child's Name</b> _____	<b>Date of Birth</b> ____ / ____ / ____
<b>Home Address</b> _____	<b>City/State</b> _____ <b>Zip</b> _____
<b>School Attending</b> _____	<b>Home Telephone</b> _____
<b>Mother's Name</b> _____	<b>Work</b> _____ <b>Cell</b> _____
<b>Father's Name</b> _____	<b>Work</b> _____ <b>Cell</b> _____
<b>Family Email Address</b> _____	

**Medical/Health Insurance Information**

<b>Physician Name</b> _____	<b>Physician Phone</b> _____
<b>Physician Address</b> _____	
<b>Dentist Name</b> _____	<b>Dentist Phone</b> _____
<b>Dentist Address</b> _____	
<b>Health Ins Plan</b> _____	<b>Member Svcs Telephone</b> _____
<b>Group #</b> _____	<b>Policy #</b> _____

**Parent Medical Treatment Authorization**

I/We, the parents of the above named child who is enrolling in the ACL Injury Prevention Summer program conducted by Central Texas Pediatric Orthopedics & Scoliosis Surgery (CTPO), hereby give my/our approval to participate in any and all activities conducted as part of the program. Other than those listed below, my/our child has no physical or mental limitations or impairments, is currently taking no medication, and has no allergies which I/we feel is important and should be disclosed to CTPO.

\_\_\_\_\_  
(if none, indicate "none")

I/We know that participation in sports programs at CTPO, and in general, may result in serious injuries and with knowledge of this do hereby waive, release, absolve, indemnify and agree to hold harmless CTPO and its Board of Directors and staff, sponsors, supervisors, and participants for any claim arising out of any injury to my/our child whether the result of negligence or for any other cause, except to the extent and in the amount covered by accident liability insurance.

In the event of injury or illness to my child, \_\_\_\_\_ (name of child), I/we hereby grant authority to a licensed medical doctor to render such medical treatment as said doctor deems necessary under the circumstances. (MUST BE SIGNED BY BOTH PARENTS. IF NOT, STATE REASON ON VACANT SIGNATURE LINE.)

\_\_\_\_\_  
Mother's Permission Granted

\_\_\_\_\_  
Father's Permission Granted