RELEASE OF LIABILITY / CONSENT FORM

| AIM San Diego West adult for the Fall 2022 through Summer 2023 sessions. | |
|---|---|
| As consideration for being permitted by AIM San Diego West or affiliates to participate in these activities, I hereby agree that I, my representatives and assigns will not make a claim against AIn San Diego West any of its affiliated organizations, employees or representatives, for injury or dama to my person or caused, by an employee, agent, representative or contractor of AIM San Diego Wor its affiliated, as a result of my participation in any AIM San Diego West or its affiliates' activities which include, but are not limited to practicing pantomime, various aerobic exercise, traveling to a from performances and volunteer work in our communities. In addition, I hereby release and discharge AIM San Diego West and its affiliated organizations, employees, agents and representative from all claims, actions or demands I, my representatives or assigns now have or may hereafter has for injury or damage resulting from my participation in these activities. I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. AM AWARE THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN AIM SAN DIEGO WEST AND MYSELF, AND I SIGN IT OF MY OWN FREE WILL. | Mage Yest es and ves ave |
| SIGNATURE OF PARTICIPANT: | |
| SIGNATUREDATED | |
| PRINT NAMEPHONE | |

AUTHORIZATION FOR TREATMENT

The following is a legal document that will authorize any treatment necessary

| | AIM San Diego West or all sign in the appropriate p | any of their affiliates. Please read places. | | | |
|--|---|--|--|--|--|
| under the general or spemergency room staff Act; or a dentist licens the staff of any acute sphospital from this state authorization is given care being required, by which the aforementic may deem advisable. underwritten prior to retreatments will not be | pecial supervision of any licensed under the provised under the provisions of general hospital holding are's Department of Public in advance of any specification of the provide autoned physician in the exert is understood that effort | and consent to any X-ray agnosis and treatment rendered member of the medical staff and sions of the Medicine Practice of the Dental Practice Act, and on a current license to operate a Health. It is understood that this ic diagnosis, treatment or hospital shority and power to render care recise of his/her best judgment or shall be made to contact the e patient, but that any of the above ned cannot be reached. | | | |
| Date Sign | nature for Medical Releas | se | | | |
| Telephone numbers of parents/guardians, or significant party in case of emergency: | | | | | |
| Father: | Home:/ | - Work: / - | | | |
| Mother: | Home: / Home: / | - Work: / - | | | |
| Guardian: | Home: / - | - Work: / | | | |
| Other: | Relationship: | Phone: / - | | | |
| Family Doctor's Name | | Phone:/ | | | |
| Do you have any aller | gies or medication needs | ? If yes, please explain. | | | |

<u>VERIFICATION OF</u> <u>INSURANCE COVERAGE</u>

Every AIM San Diego West participant is required to have current major medical and accident insurance. AIM San Diego West or any of their affiliates cannot be responsible for payment of any medical costs (personal or accidental) that you may incur while participating in this event, so please complete the following section with the appropriate information.

| Insurance Company: | | | |
|--|-------------------|---------|------------|
| Policy or group #: | _Exp. Date: | / | / |
| Name: | | | |
| I have read the above information and I und not responsible for my medical expenses. | lerstand that AIN | I San I | Diego West |
| | | / | / |
| Signature | Date | | |

I have read the above information and I understand that AIM San Diego West and/or any of their affiliates are not responsible for my medical expenses and that I must supply my own medical insurance in order to be eligible for this event of AIM San Diego West and/or Affiliates.