| **Student Information** | | | **Class** | **Fee\*** |
| --- | --- | --- | --- | --- |
| **#1** | Name: |  |  |  |
| Chinese name: | Date of birth: |  |  |
| Health concern / allergies: |  |  |  |
| **#2** | Name: |  |  |  |
| Chinese name: | Date of birth: |  |  |
| Health concern / allergies: |  |  |  |
| **#3** | Name: |  |  |  |
| Chinese name: | Date of birth: |  |  |
| Health concern / allergies: |  |  |  |
|  |  |  | Registration Fee\*: |  |
|  | Please make check payable to: Westlake Chinese Culture Association | | Subtotal: |  |

| **Family information** | |
| --- | --- |
| Home Phone#: | Email: |
| Address: |  |
| For children, Parent or Guardian’s name: | Chinese Name: |
| For children, Parent or Guardian’s name: | Chinese Name: |

| **Emergency Medical Authorization** | | |
| --- | --- | --- |
| **Significant health concerns may be shared confidentially with an appropriate school or camp personnel to ensure the student’s health and safety.** | | |
| To authorize the provision of emergency treatment for students who become ill or injured while under school authority. Please list only the names of those who have the **authority to make decisions** in an emergency situation involving the above students.  [AT LEAST ONE MUST BE COMPLETED] | | |
| Contact person #1: | Phone#: |  |
| Contact person #2: | Phone#: |  |
| In the event reasonable attempts to contact the above contacts have been unsuccessful, I hereby give my consent for (1) the administration of treatment deemed necessary by the preferred doctor indicated, or, in the event the designated practitioner is not available, by another licensed physician or dentist: & (2) the transfer of the student to the preferred hospital indicated, or, to the closest accessible hospital, if necessary. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.  [PART 1 **OR** PART 2 MUST BE COMPLETED] | | |
| PART 1: I hereby consent for the following medical care providers to be called: | | |
| Preferred Physician: | Phone#: |  |
| Preferred Dentist: | Phone#: |  |
| Preferred Hospital: | Phone#: |  |
| PART 2: I do NOT give my consent for emergency medical treatment of above students. In the event of illness or injury I wish the school or camp personnel to take the following action(s): | | |
| **Signature** (or parent/guardian’s) | | **Date** |

| \* Class code & registration fee: Refer to School Handbook | |
| --- | --- |
| [For Office Use Only] |  |
| Date Received: | Check No. |