MA	ANNA'S MARTIA	ALARTS	Keep on file for all programs until notified	
ENROLLMENT APPLICATION Part 3 of 3			REQUESTED AGE SPECIFIC PROGRA	
-1111	DELINENT ALL EIGATION	Truit o or o	☐ Tiny Tigers (Ages 3 & 4) ☐ Try It Program	
PAF	RTICIPANT	1	Little Dragon (Ages 5 & 6) Birthday Party	
NAME			☐ Dragion (Ages 7 through 11) ☐ After School Pro	gram
	Flet	Lest	─ Teen/Adult (Ages 12 to 29) ☐ Summer Activity	
E-MAII	L:		Songin (Minimum age 30) Untreach Progra	m at:
HOME	PHONE: ()		Kickboxing (Min. Ages 12)	
Con	sent To Treatment o	of Minor 🤲	MANNA'S MEMBER #:	
	AUTHORIZATION TO CONSENT	TO TREATMENT OF MINOR	R	
	to any X-ray, anesthetic, medical, advisable by, and is to be rendere	Manna's Martial Arts employee or surgical diagnosis or treat d under the general, other ca geon licensed under the prov	e as agent(s) for the undersigned to cons ment and hospital care which is deemed are giving, medical treatment or special s vision of the Medical Practice Act whether or at the hospital or on location.	upe
	It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent (s) to give specific consent to any and all such diagnosis, treatment or hospital care which a physician, meeting the requirements of this authorization may, in the exercise of his/her best judgement deem advisable. Neither said agent or any organization involved assumes any financial responsibility for exercising this action. (I) (We) hereby authorize any hospital which has provided treatment to the above named minor pursuant to the provisions of Section 25.8 of the Civil Code or succive code thereto of California to surrender physical custody of such minor to (my) (our) above named agent(s) upon completion of treatment. This authorization is given pursuant to Section 1238 of the Health and Safety Code or succive code thereto of California.			
	Initial here:	Signature (Parent/Legal Guardian	i)	Date:
	Parents address and phone numb	oer		_
	Allergies:			_
	Medications Currently Taking:			
	Insurance Company:	Card copy	attached yes no	-
	Group # or ID #			_
	Physician	Phone #:		_
	Other information:			_
	Parent or Guardian		Date	