


Childs Name		DOB		GENDER	M	F
Parent Name	Child Class/day time.					
Phone number	Home:	Cell:	Work:	Email:		
Address				City	Zip code	
Does your child have any allergies or medical conditions we should be aware of?				Yes	No	
Please explain:			Tylenol/Advil	Yes	No	
Name:		Phone:		Name:		Phone:
Emergency contact primary			Emergency contact secondary			
<p>As a parent or authorized representative, I hereby my child attend WVSD Fall program. I will not hold World <b>Voices San Diego, WVSD</b> liable of any accidents, physical or other injury from any and all claims, demands, costs, expenses, and compensation, as well as WVSD independent instructors <b>and other participants'/OTA Old Town Academy</b>. I acknowledge all the risks on his/her behalf and likewise assume all responsibility for any injury or damage that might occur. In case of emergency, I give my permission to the above named program to obtain medical and/ or dental care prescribed be a duly licensed physician (M.D.), Osteopath (D.O.), or dentist (D.D.S) for my child. This care may be given under whatever conditions necessary to preserve the life, limb, or well-being of my child. I agree to the above terms freely and voluntarily without inducement for myself and on behalf of my child. By signing this document, I also accept the terms and conditions on <b>WVSD</b> website page/terms and conditions, and I acknowledge my child will be enrolled in this program.</p>						
Signature			Print name		Date	
<a href="mailto:info@worldvoicessd.com">info@worldvoicessd.com</a>			<a href="http://www.worldvoicessd.com">www.worldvoicessd.com</a>		858 623-9675	



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