WAX EYE SPORTS AND PERFORMING ARTS TRUST INC.

P.O Box 69271
Auckland
New Zealand

Registration/Medical Form
Fees: Donation or Koha on the day

First Name: ……
Surname: ……
Address: ……
……..
……..

Parents Name: ……

Phone Work: ……
Home: ……
Mobile: ……

Emergency:
Phone/Contact: ……..

Doctors Details (Confidential)
Family Doctor: ……
Doctors Phone No: ……..

My / our child is taking the following medication (Please specify)
Type of Medication: ……..

Medical Condition/Allergy and previous injuries
……

I give permission for my child to attend WESAPAT INC. training programme and to act for my child in an emergency. I hereby waive and release from any liability of injuries sustained to my child whilst in attendance of and during each training session. I accept full responsibilities for my child's medical bills and associated expenses as a result of injury or illness sustained whilst in attendance of the WESAPAT INC) training programme.

Signed:……. (Parent/Guardian)

Date:----------