



KEY CLUB

Torrey Pines High School

2017-2018 Member Application

Name: _____

Email: _____

Home Phone Number: (____) _____ Returning Member: Yes No

Cell Phone Number: (____) _____ Grade: 9 10 11 12

Birthday: _____

Address: _____

Any ideas for community service projects? Tell us!

Key Club can put my photo in a service gallery on the online blog or in a monthly newsletter: Yes No

Please return this form, the medical authorization form, the discipline agreement form, and \$12 dues payment by November 1st to our Treasurer, Christy Lam. These dues go to Key Club International to confirm your membership in Key Club. We allow students to attend 3 of our events without paying dues in order to see what type of community service we do. You can still sign up for Key Club after November 1st, but dues will increase to \$15. You will receive an official membership card and an informational packet from Key Club after dues have been processed. If paying with a check, please make it payable to TPHS Key Club. Visit tphskeyclub.weebly.com for more information, or email tphskeyclub@gmail.com with any questions.

Cali-Nev-Ha District



Key

Club International

Consent for Attendance and Medical Authorization

I am a parent or legal guardian of _____ (my child)
and give my consent as follows:

1. For my child to attend Key Club events, which are official functions of the California-Nevada-Hawaii District of Key Club International.
2. For any responsible adult who is acting as a chaperon for my child is authorized to obtain any medical and/or dental treatment for my child which the chaperone in their sole discretion may deem necessary. Any medical doctor, dentist, hospital or other treatment facility is requested to cooperate with the chaperone if they request medical or dental treatment for my child. This medical authorization shall include but shall not necessarily be limited to hospitalization, our patient treatment, the giving of medications, injections, blood transfusions, surgery, x- rays, physical therapy or any other forms of medical or dental treatment whether or not specifically listed herein; provided however, that the adult consenting or authorizing such treatment shall have first attempted to contact me at the telephone number set forth below unless the need for treatment results from emergency situations that require immediate treatment such that a prior attempt to contact me is not practical or reasonable.

My child has the following known allergies or medical conditions:

My child is taking the following medications:

Medical Insurance

Policy Carrier: _____ Policy Number: _____

(Parent/Guardian Signature)

(Emergency Phone #)

(Date)