MEDICAL INFORMATION AND RELEASE – Under 18
Mountain Youth and Community Theatre 2016
(Please print legibly on both pages)

Student Name____

Date of Birth___/___/___ (please circle one) Male or Female

Mailing Address__________________________________Home Phone #________________
(Address, City, State and Zip)

Mother's Cell #___________________text? Yes No Cell Carrier:______________________

Father's Cell #____________________text? Yes No Cell Carrier:______________________

Student Cell #____________________text? Yes No Cell Carrier:______________________

Email address:____

Any allergies? (if yes, please explain)____

____

Any medications? (if yes, please explain)_________________________________

____

Any medical conditions? (if yes, please explain)______________________________

____

PARENT/GUARDIAN INFORMATION

Name______________________________Phone #______________________

Address____

EMERGENCY CONTACT INFORMATION

1. Name___________________________ Home Phone #_________________

Address___________________________ Work Phone #__________________

Relationship to Student__________________

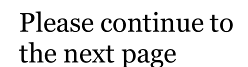
2. Name___________________________ Home Phone #_________________

Address___________________________ Work Phone #__________________

Relationship to Student__________________

INSURANCE INFORMATION

Medical Insurance Carrier_____________________________



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HEALTH CARE PROVIDER

Pediatrician Name ______________________ Phone_______________________

Address____

MEDICAL TREATMENT AUTHORIZATION

To Whom It May Concern:

I, __________________________ authorize that any agent, employee, independent contractor or volunteer of Mountain Youth and Community Theatre (hereafter referred to as child care providers) are child care providers for my child, ______________________________. Child care providers are responsible for their care and welfare during the day, and occasionally in the evenings, on the weekends or overnight.

I hereby authorize and voluntarily consent to having child care providers arrange, direct, sign for and consent to any and all routine or emergency medical care and treatment necessary to preserve the health of my child. Personal, insurance and health care provider is set forth above.

I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered and acknowledge that no guarantees have been made as to the effect of such treatment rendered.

Parent/Guardian Signature____________________________ Date______

Parent/Guardian Name (printed)________________________