



Authorization for Medical Treatment

Student Name _____

Parent Name (s) _____

Complete Mailing Address _____

Home phone number (s) _____

Work phone numbers (s) _____

Please name two people to contact in case you can't be reached in an emergency situation:

1) Name _____ Phone _____

Relationship _____

2) Name _____ Phone _____

Relationship _____

Please list any medication that your child is taking. TheatreWorks dispenses no medication. Please note if a student has medication for self-use and if refrigeration is required.

Please list any allergies that your child has, including medication, food or animals.

Please list any conditions that your child has that may prevent him or her from participating in any physical activity.

Please provide us with your health insurance information:

Insurance Carrier _____

Group/Policy Number _____

Patient ID Number _____

In case of serious accident or illness involving my child while he/she is in the custody of TheatreWorks or its employees, every effort will be made to contact parent or guardian. A situation may arise when emergency treatment may be necessary and the parent or guardian cannot be reached. In such situations, I hereby authorize Camp personnel to make provisions for treatment with the appropriate medical personnel or facility.

Signature _____ Date _____