



Youth Theatre 2010

Emergency Contact Information

Child's Full Name: _____ Nickname: _____
Birth Date: _____

PARENT CONTACT INFORMATION

Name(s): _____
Mailing Address: _____

E-Mail Address: _____

Home: _____ Work: _____ Cell: _____

MEDICAL INFORMATION

CONTACT PERSON IN CASE OF EMERGENCY IF PARENTS ARE NOT AVAILABLE

Name: _____ Phone: _____
Relationship to Child: _____

ALLERGIES, MEDICAL CONDITIONS, OR OTHER IMPORTANT INFORMATION WE SHOULD KNOW: _____

PLEASE LIST ANY MEDICATIONS YOUR CHILD IS TAKING:

AUTHORIZATION FOR EMERGENCY CARE & TREATMENT

I authorize TriArts to administer care and treatment for injuries and illnesses my child may incur while at camp. I authorize the release of information and medical records to facilitate the medical, surgical and psychiatric care of my child. In the event of any emergency, illness or injury in which a delay may jeopardize the life of the recovery of my child and I am unable to be contacted, I authorize the theatre or its representatives to assume responsibility for the care and treatment of my child which may include hospitalization, diagnostic tests, and/or surgery.

Parent / Guardian Name: _____

Signature: _____ Date _____