



The Little Theatre On The Square
and
Sullivan Civic Center
Dance and Drama
MEDICAL RELEASE FORM

I, _____ hereby give permission for any and all
(parent / guardian)
medical attention to be administered to my child _____
(Child's Name)
in the event of accident, injury, sickness, etc., under the direction of the
physician(s) listed below or at any necessary emergency facility, until such
time as I may be contacted. I also assume the responsibility for the payment
of any such treatment. This release is effective for the period of one year
from the date given below.

PARENT / GUARDIAN NAMES: _____

PARENT / GUARDIAN ADDRESS: _____
(Street Address)

(City, State, Zip) PHONE #: _____
(Emergency Contact Number)

HEALTH INSURANCE COMPANY: _____
(Insurance Company Name)

HEALTH INSURANCE POLICY # : _____
(Group Number and Policy Number)

CHILD'S PHYSICIAN: _____
(Primary Care Physician)

PHYSICIAN'S OFFICE ADDRESS: _____
(Street Address)

(City, State, Zip) PHONE #: _____
(Physician's Office Number)

KNOWN ALLERGIES / HEALTH CONDITIONS: _____

SIGNATURE: _____ DATE: _____
(Parent / Guardian)