# CHILDREN'S MUSICAL THEATRE WORKSHOP, INC.

A NON-PROFIT 501 (C)(3) CORPORATION
SERVING THE CHILDREN OF VOLUSIA AND FLAGLER COUNTIES
Please visit our website
www.cmtworkshop.org

# MEDICAL RELEASE STATEMENT

Name of Minor Child/Youth:_____ Date of Birth: _____ Gender (M/F) _____

Parent(s)/Guardian Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Email address: _____

Parent(s)/Guardian Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Email address: _____

## PARENT OR LEGAL GUARDIAN AUTHORIZATION:

In case emergency, if family physician cannot be reached, I hereby authorize my minor child to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R. Physician)

Be advised that in my absence, Cynthia Simmons, Jennifer Simmons, Christine Simmons, Jennifer Campanella, and/or Nancy Jo Mosser with Children's Musical Theatre Workshop, Inc. have my permission to admit my minor child/youth in case of emergency for any medical treatment.

I hereby authorize the performance of any necessary emergency medical an surgical procedures under local and/or general anesthesia, which may be advised by attending physicians of my minor child/youth while patient of any U.S. hospital. Furthermore, I respectfully request the use of any hospital's services or facilities, which may be regarded as necessary or beneficial in the performance of said procedure.

Let this be your authority to treat and admit your minor child/youth.

Family Physician : _____ Phone: _____

Address: _____ City: _____ State/Zip: _____

Hospital Preference: _____

Parent Insurance Co: _____ Policy No: _____ Group ID#_____

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If parent(s)/legal guardian cannot be reached in case of emergency, contact:

| Name | Phone | Relationship to minor/youth |
|---|---|---|

| Name | Phone | Relationship to minor/youth |
|---|---|---|

Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder)

Medications currently being taken :_____

Minor child/youth is permitted to take:
Please circle all that apply: Tylenol Advil Motrin Aleve or _____ for headaches.

Yes: _____ No: _____ (please initial yes or no)

The purpose of the above listed information is to ensure that medical personnel have details with any medical problem that may interfere or alter treatment.

Mr./Mrs./Ms. _____
Authorized Parent/Guardian Signature Date:

Mr./Mrs./Ms._____
Authorized Parent/Guardian Printed Name Relationship to minor/youth

STATE OF FLORIDA
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20_____, by

_____, who is personally known to me [____] or produced

_____ as identification.

(SEAL)

Notary Public: _____

Print Name: _____
My Commission No.:
My Commission Expires: