Sample Medical Treatment Authorization Form - Child

MEDICAL TREATMENT AUTHORIZATION note: a new authorization is required for each production.

Name of Child _____ Age of Child _____ Grade in School ____

Name of Holiday Spectacular, Inc Production Circle one

Holiday Spectacular Celebrate America Princess Coronation Broadway to Bloomington Broadway to Bloomington Jr.

I hereby request permission to participate in the aforementioned Holiday Spectacular, Inc production and I understand that the production, by its very nature, includes certain inherent risks and could cause minor injury, major injury, and serious injury, including permanent disability and death. In the event of illness or injury, in my absence, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, emergency transportation, and hospital care considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

I further acknowledge that the Holiday Spectacular, Inc does not provide liability or medical insurance coverage for participants who participate in this class/activity.

_____ I have no special health needs the staff should be aware of, and no medication is required during this class/activity.

_____ Other: _____

Med. Insurance Carrier: _____Policy Number: _____ Hospital _____

In the event of an emergency, please contact: _____or _____

Phone or cell #: (   ) _____ Home: (   ) _____ Relationship:_____

One Check and Parent/Guardian Signee's(') or Participant's (if 18 or older) Initials for Each Line is Required:

YES	NO	Initials	Health or Special Need
			Participant has no special health needs the staff should be aware of, and no medication is required.
			Participant has a chronic allergic condition or temporary medical or physical condition, and instructions are attached. No. of attached pages: _____.
			Participant has a special need covered by Section 504 and/or an individualized education plan (IEP).
			Other (please describe): No. of attached pages: _____.

_____ Parent/Guardian Signature(s)   Date _____
    (If participant is under age 18)

_____ Parent/Guardian Name(s) _____ Phone Number(s)
          please print