

The Brecksville Theatre

EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name _____ DOB _____ Age _____ Grade _____
Address _____ City _____ Zip _____
Home Phone _____

Residential Parent(s) or Guardians

Home Phone _____ Cell Phone _____
Mother _____ Contact Number _____
Father _____ Contact Number _____
Other _____ Contact Number _____

Other Relatives or Childcare Providers:

Name _____ Contact Number _____ Relationship _____
Name _____ Contact Number _____ Relationship _____

Granting Consent:

I hereby give consent for the following medical care providers and local hospital to be called in the event of an emergency (or reasonable attempts to contact me have been unsuccessful—applicable for child students/actors). This consent is for (1) administration of any treatment deemed necessary by my selected doctors or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concur in the necessity for such surgery and are obtained prior to the performance of such surgery.

Physician _____ Phone _____
Dentist _____ Phone _____
Medical Specialist _____ Phone _____
Preferred Hospital _____ Emergency Phone _____
Insurance Provider _____ Group or ID # _____

Facts concerning medical history, including allergies, medications being taken, and physical impairments to which any physician should be alerted:

Parent/Guardian Signature

Date

Refusing Consent:

I do **NOT** give my consent for emergency medical treatment of cast member/student named above. In the event of illness or injury requiring emergency treatment, I wish The Brecksville Theatre personnel to take the following actions:

Parent/Guardian Signature

Date