MEDICAL RELEASE FORM

THIS FORM SHOULD BE COMPLETED *BEFORE YOUR AUDITION.*
Please fill in the form electronically; on our website [fivestartheatre.org]

Minor's Name: Date of Birth:

Last First M.I. Mo/Day/Yr

Parent's Name_____

Home Address_____ City_____ State____ Zip Code _____

Home Phone_____ Cell Phone _____

Employer_____ Work Phone_____

Insurance Carrier's Name and Address_____

Policy Number_____

Notify in Emergency _____ Relationship _____
(if other than parent or guardian)

Address_____ City_____ State _____ Zip _____ Phone_____

Family Physician_____ Phone_____

Allergies_____ Last Tetanus_____

Medical Problems_____

_____

Medications (include dosage/frequency)_____

Behavioral and/or Mental Health Concerns we need to be aware of:_____

_____

AUTHORIZATION FOR TREATMENT OF MINOR

I, the undersigned, parent or legal guardian of _____, a minor, do hereby consent to the physician selected by the Program Director or THE FIVE STAR THEATRE COMPANY to perform routine tests and treatment for the health of my child. In the event I cannot be reached in an Emergency, I hereby give permission for the physician selected by the Program Director or THE FIVE STAR THEATRE COMPANY to secure proper treatments for my child as named above.

In the event of any emergencies during THE FIVE STAR THEATRE COMPANY'S SUMMER PROGRAM 2024 (June 29 -July 25), the undersigned hereby grants authority to be exercised at the discretion of Mr. Bill Endslow or Miss Kristin Killian to dispense over-the-counter medication.

_____ _____
Date Signature of Parent/Guardian