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:________________

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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 (July 1 - 27), 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