SCTC Friday VIP Camp Medical Release and Consent Form

Valid from Friday, August 20, 2010
Valid Through Friday, June 10, 2011

General Information:

Camper's Name:
Guardian Name:
Best Phone Number:
Address:
Zip Code:

Emergency Contact Information:

Name: Phone :
Name: Phone :

Medical Information:

Doctor's Name: Phone:
Dentist's Name: Phone:
List any Medical Conditions or Illnesses: (ex. Migraines, Asthma, Diabetes etc.)

List any Allergies: (ex. foods, insects, etc.):

Does your child have a chemical allergy? (please circle) YES NO
If yes, please describe:

Is your child allergic to any make-up? (please circle) YES NO
If yes, please describe:

Please list any medication (including over the counter) the stage manager will need on hand during performances:

Disabilities and Special Needs

Does your child have any visual impairment? (please circle) YES NO
If yes, please describe:

Does your child have any hearing impairment? (please circle) YES NO
If yes, please describe:

Does your have any physical impairment? (please circle) YES NO
If yes, please describe:

Does your child have any learning disabilities? (please circle) YES NO
If yes, please describe:

Please list any special needs we should be aware of: _____

_____

_____

Medical Release:

This consent form gives permission of the SCTC or Pueblo City Schools staff to seek whatever medical attention is deemed necessary for my child, and releases SCTC and Pueblo City Schools and its staff of any liability against personal losses.

I authorize the SCTC Staff to receive pertinent medical information for my child and to consent to any X-ray, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician.

The undersigned shall be liable and agree(s) to pay all costs incurred in connection with such medical and dental service rendered pursuant to this authorization.

Signature of Guardian _____

Printed Name _____

Date _____