

STAGE DOOR CONSERVATORY

Emergency Instructions and Contact Information – STAFF

Staff Name _____ Birth Date _____

Address _____

Home Phone _____ Email _____

EMERGENCY CONTACT INFORMATION

Name _____ Day Phone _____ Relationship _____

Name _____ Day Phone _____ Relationship _____

Name _____ Day Phone _____ Relationship _____

Name _____ Day Phone _____ Relationship _____

CONSENT FOR MEDICAL TREATMENT

I do hereby consent to any examinations, x-rays, medications and anesthesia, and surgical treatment that may be required to maintain my health and well-being if they are recommended by either (1) the attending physicians overseeing my care or (2) one or more of those physicians I have named in the accompanying STAGE DOOR CONSERVATORY Health Form. It is understood that this consent is given in advance of any accident or illness that may require diagnosis and treatment, but is given to encourage physicians to use their best judgment and to proceed immediately with any necessary treatment. This authorization for diagnosis and treatment is valid only in the event that I cannot make medical decisions on my own behalf and shall remain in effect until revoked in writing.

In case of a medical emergency, I give my permission to be transported to the following hospital at my expense:

<i>Name</i>	<i>Address</i>	<i>Phone</i>
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If no hospital is listed above, I permit and authorize STAGE DOOR CONSERVATORY personnel to transport or arrange ambulance transportation to the nearest emergency facility (ALTA BATES HOSPITAL).

I agree to assume any and all risk of accident or injury that I may sustain from whatever cause in connection with his or her participation in STAGE DOOR CONSERVATORY's day camp. I further agree to hold Stage Door Conservatory, its employees, agents and Board of Directors, harmless should any accident or injury occur to my child. I understand that no medical insurance is provided by STAGE DOOR CONSERVATORY itself.

Signature: _____ Date _____

STAGE DOOR CONSERVATORY

Health Form

Name _____ Birth Date _____

MEDICAL INSURANCE

Physician's Name _____ Phone _____

Physician's Address _____

Health Insurance Provider _____

Child's Medical Subscriber # _____ Group # _____

Child's Date of Birth _____

I have the following allergies:

ALLERGY	Reaction	Treatment

I have the following drug sensitivities:

ALLERGY	Reaction	Treatment

I have the following medical conditions (i.e., asthma):

CONDITION	Necessary precautions	Treatment – Please attach additional instructions if needed

SPECIAL NOTES:

SIGNATURE: _____ DATE: _____