Medical Release Form

CHILD'S NAME: _____
(Last) (First) (Middle)

ADDRESS: _____
(Street) (City) (State) (Zip)

DATE OF BIRTH: _____
(Mo.) (Day) (Year)

HEALTH/ACCIDENT INSURANCE CARRIER: _____

POLICY NO.: _____ GROUP NO.:_____

PERSONAL PHYSICIAN: _____

PHYSICIAN'S ADDRESS: _____
(Street) (City) (State) (Zip)

PHYSICIAN'S PHONE NUMBER: _____

PARENT, LEGAL GUARDIAN, OR OTHER PERSON WHO HAS LEGAL AUTHORITY TO AUTHORIZE MEDICAL TREATMENT TO PARTICIPANT IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

HOME #: _____ WORK # _____ CELL #: _____

Please list any chronic or acute medical problems (Continue on back if needed): _____
_____

Please explain any special considerations we need to know related to the above conditions:
_____

List any allergies to food, pollen, or medicine: _____

List any medications being taken at present: _____
_____

I ACKNOWLEDGE THE PARTICIPANT'S IMMUNIZATION ARE CURRENT: _____YES _____NO

My child plans to attend the San Angelo Museum of Fine Arts' Junior Mentor Program. I fully realize injury or illness could result from or during my child's participation in the camp. In case of accident or illness, I give my permission for my child to receive medical treatment as deemed appropriate. I will assume responsibility for any medical bills.

_____ _____
PARENT/LEGAL GUARDIAN'S SIGNATURE PARENT/LEGAL GUARDIAN'S NAME PRINTED DATE