CIRCLE ARTS THEATRE
Medical History & Release Form

PERSONAL INFORMATION

NAME		
DATE OF BIRTH / /	AGE	SEX
PARENT(S) / GUARDIAN		
ADDRESS		
CITY	STATE	ZIP
E-MAIL	CELL PHONE	
HOME PHONE	WORK PHONE	

MEDICAL INFORMATION

PHYSICIAN	
PHONE	ADDRESS
CURRENT MEDICATIONS	
DRUG ALLERGIES	FOOD/OTHER ALLERGIES
Does your child have any other special needs or medical conditions of which we should be aware?	

HEALTH INSURANCE

PROVIDER	GROUP #
ADDRESS	SUBSCRIBER #

EMERGENCY CONTACTS

# 1	NAME	RELATIONSHIP
	HOME PHONE	CELL PHONE
#2	NAME	RELATIONSHIP
	HOME PHONE	CELL PHONE

WAIVER OF LIABILITY & MEDICAL TREATMENT AUTHORIZATION

I do hereby appoint CIRCLE ARTS THEATRE to act on my behalf in regards to my child, in the event that I cannot be contacted, to authorize or refuse necessary emergency treatment while my child is participating in class and related events. I understand and agree that I will be responsible for the payment of all costs incurred incident to such treatment. I will not hold CIRCLE ARTS THEATRE or any of its Staff Members in any way responsible for accidents and/or injury to the child that are wholly or in part resulting from participating in class events.

Print Name	Date
Signature	Date