

**Primary Insurance Company:**

Phone #s: ( ) - ( )  
Billing Address:

Policy Holder's Name:

Address:  
Relationship to child/children:

ID #: Group/Policy #:

**Secondary Insurance Company:**

Billing Address:

Policy Holder's Name:

Address:  
Relationship to child/children:

ID #: Group/Policy #:

**Statement of Consent:** *(To be signed in the presence of a legalized notary public.)*

*In the event of an emergency or non-emergency situation requiring medical treatment, I, \_\_\_\_\_, hereby grant permission for any and all medical and/or dental attention to be administered to me or my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.*

Signature: Date:

**Notarization:**

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(date)(month)(year)(name of parent) personally appeared before me in \_\_\_\_\_  
County (in the state of \_\_\_\_\_)and, in my presence signed this medical release  
form.

Name of Notary Official:

Signature:

Commission Expires:

# *Imperial Percussion Theater*

## Medical Release Form

(If under the age of 18 this release MUST be filled out by Parent/Legal Guardian)

Member(s) Name \_\_\_\_\_

Parent/Legal Guardian's Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

\_\_\_\_\_

Phone #s:

Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Other (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**In an emergency, please contact:**

\_\_\_\_\_

Relationship to Member(s) \_\_\_\_\_

Phone #s: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Secondary Emergency Contact:**

\_\_\_\_\_

Relationship to Member(s): \_\_\_\_\_

Phone #s: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Physician's Name:**

\_\_\_\_\_

Address:

\_\_\_\_\_

Phone #s: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Dentist's Name:**

\_\_\_\_\_

Address:

\_\_\_\_\_

Phone #s: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_