

# RED RIVER DANCE THEATRE COMPANY

P. O. BOX 486, ALEXANDRIA, LA 71309-0486

(318) 443-7500

## MEDICAL RELEASE FORM

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

Address \_\_\_\_\_

City/St/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Mother \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone \_\_\_\_\_

Father \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

In case of emergency and neither parent can be reached, please contact

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Work Phone \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medical information that we should be aware of (medical history, allergies, regular medications, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Any "over the counter" drugs not to be used would include \_\_\_\_\_

\_\_\_\_\_

Any current medications \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Which parent has the insurance?    Father            Mother            Other    \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Medical Insurance Policy/Plan # \_\_\_\_\_

Prescription Drug Company & Plan # \_\_\_\_\_

Copy of insurance card (front & back) attached

I hereby authorize Red River Dance Theatre Company to obtain the services of a licensed physician, emergency room personnel, nurse or ambulance personnel in the event of an emergency or injury while participating in Company activities. I also understand that this information will be retained on file and used in the event that medical attention is required for my child or children during such activities. This authorization is valid until revoked in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent or Guardian)