A.P.A. - ACADEMY OF PERFORMING ARTS
MEDICAL RELEASE FORM

I, ________________ (parent/guardian's name) herby give permission for any and all medical attention to be administered to my child ____________ (child's name) in the event of an accident injury, sickness, etc., under the direction of the physicians listed below or at any necessary emergency facility, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

ADDRESS:____

HOME PHONE:____

INSURANCE COMPANY:_______________________________________

POLICY NUMBER:____

CHILD'S PHYSICIAN:____

ADDRESS:____

PHONE:____

KNOWN ALLERGIES:____

LIST ANY CURRENT MEDICATIONS:____________________________

SIGNATURE(PARENT/GUARDIAN):_______________________________

DATE:____