

PERFORMING ARTS ACADEMY OKLAHOMA CITY UNIVERSITY
Medical Release / Emergency Contact Information

PLEASE PRINT THIS FORM, FILL IT OUT COMPLETELY AND RETURN

Student Name: _____

Date of Birth: _____

SSN. Number: _____ - _____ - _____

(Required by physicians and hospitals – all information shredded following program)

Parent or Guardian Authorization:

I request that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Family Physician: _____ Phone: (____) _____

Address: _____

Hospital Preference: _____

EMERGENCY CONTACT (Primary): _____

Phone Numbers: Home: (____) _____ Work: (____) _____

Other: (____) _____ Relation to Participant: _____

EMERGENCY CONTACT (Secondary): _____

Phone Numbers: Home: (____) _____ Work: (____) _____

Other: (____) _____ Relation to Participant: _____

Does the participant have any special medical or other needs of which we need to be aware? Please

Describe: _____

Please Note: We are not equipped to deal with eating or emotional disorders that may hinder your child's participation in our program. Students whose ability to participate in the program is questionable may be sent home after evaluation and discussion with the parents.

