Columbia Dance Academy

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Emergency Treatment Authorization

To Whom It May Concern:

As parent and/or legal guardian of ________________________________, a minor child, I herewith authorize treatment of said minor by a qualified and licensed medical doctor in the event of a medical emergency which in the opinion of the attending physician may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of parent or guardian:____
Address:____
City:___________________ State:____________ Zip:________________________
Phone – home:______________________ office:___________________________
Family Physician or child's Pediatrician:_________________________________
Phone – office:______________________ exchange:_________________________

Specific Medical Information - - allergies, chronic illnesses, other medical conditions or information:

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Other contact in case of emergency:

Name:_________________________________
Phone – home:__________________________ office:___________________________
Relationship to minor child____

This release is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence. It shall remain in effect until revoked by me in writing.

Signed:____
Parent or guardian

Date:____