

# Archbishop Wood High School Fine Arts Department Medical Information and Release Form

Please print all information.

Student's Name \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

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I/We, the undersigned, on our behalf and the behalf of our minor dependent, do hereby authorize the members of the staff of the Fine Arts Department, or their designees, to give emergency care to my son/daughter. If necessary, permission is also given to admit my son/daughter to the nearest hospital for emergency treatment.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_

Cell # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Cell # \_\_\_\_\_

Please specify any medical or allergy conditions: \_\_\_\_\_

Does your son/daughter carry medication with him/her? \_\_\_\_\_

If yes, please specify: \_\_\_\_\_

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Insurance Information: Insurance Plan \_\_\_\_\_

Policy # \_\_\_\_\_