Consent for Medical Treatment

In the event that I cannot be contacted through reasonable efforts, I, the undersigned parent/guardian/health care agent of _____(name and age), hereby empower and grant to the Stoughton Center for the Performing Arts, Inc. (namely Coleen Kehl) permission to consent to and authorize medical treatment for the individual named above. This authorization shall be valid from September 1, 2016 thru August 31, 2017; at any function that I am not attending. I do hereby indemnify and hold harmless the health care providers and entities and other persons who act in reliance upon this authorization.

Executed this _____ day of _____, 2016.

_____
Print Name

_____
Signature

Information:
Parent/Guardian/Health Care Agent can be located at the following address:_____

Phone number:_____

Name and Address of family doctor:_____

Any known allergies/medical conditions:_____

_____

Insurance Information:

Company_____

Policy #: _____

Phone Number:_____