Spindulys Lithuanian Folk Dance Ensemble

EMERGENCY MEDICAL TREATMENT AUTHORIZATION/INFORMATION
Required for dancers less than 18 years of age

TO WHOM IT MAY CONCERN: I, _____ the undersigned, being the

parent/legal guardian of _____, hereby authorize any necessary medical treatment. In regard to such person, I submit the following information:

Allergies to foods, medication, etc. (if none so state, if yes specify):

_____

_____

Special medical problems (if none so state, if yes specify):

_____

_____

Is this dancer now under medical care? If so, describe nature of illness and treatment.

_____

_____

Does this dancer carry medication on person? (If none, so state)

Name of Medication_____

Purpose _____

IF MORE SPACE IS REQUIRED, USE BACK OF PAGE

Health Care Provider / Physician Name:_____

Provide Phone Number: _____

Insurance Company Name: _____

Insurance Policy Number:_____

Name of Emergency Contact: _____

Emergency Contact Relationship: _____

Emergency Contact Phone Number(s):_____

Parent or Guardian Phone Number(s): _____

Parent or Guardian Phone Number(s): _____

_____ _____ _____

Signature of Parent or Legal Guardian Date Relationship