STATE THEATER ARTS GUILD

BUTTE YOUTH ORCHESTRA | MEDICAL RELEASE FORM

Name of Minor _____ Date _____

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, the undersigned hereby authorizes the Butte Youth Orchestra Leader or any such substitute as may be designated as an agent for the undersigned to consent to an x-ray examinations, anesthetic, medical, dental, or surgical diagnosis or treatment and hopsital care for the above minor which is deemd advisablel by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the Provision of Medical Practice Act or of any dentitst licensed under the Dental Practice Act, whether such diagnosis or treament is rendered at the office of said physician or dentist, at a hospital, or elsewhere.

In sending your child to this event, the undersigned waives all legal claims against the Butte Youth Orchesra, its directors, officers and employees and agree to indemnify and hold harmless same from any such claims related to, or arising from, pre-hospital, first aid, and/or rescue efforts provided in accordance with the foregoing or by a designated first aid staff, be they paid or volunteer.

Parent or Guardian _____

Address _____

City _____ State _____ Zip _____

Work Phone _____ Home Phone _____

Cell Phone _____

Primary Carrier _____

Medical information (past or present) that Butte Youth Orchestra should be aware of:

_____

_____

Allergies: ____Food ____Plants ____Medicine ____Insect Bites ____Animals

Please list medications that your child is currently taking, and give informaton needed to provide as safe and full participation as possible:

_____

_____

This authorization will remain effective while the above minor is enroute to or from, involved, or participating in any Butte Youth Orchestra program or actiivty, unless revoked in writing by the above, signed and delivered to the aforesaid agent.

Parent/Guardian Signature _____

Parent/Guardian Name Printed _____