EMERGENCY MEDICAL AUTHORIZATION (WAIVER) & MEDICAL INFORMATION FORM

LAST NAME: ____________

FIRST NAME(S): ____________
(Please print)

Complete one form for all family members with the same insurance.
Use a separate form for those with other insurance.

* CONFIDENTIAL *

EMERGENCY MEDICAL AUTHORIZATION (WAIVER)

In consideration of being selected to participate in the production of Tetelestai, I, the undersigned, intending to be legally bound for myself, my minor dependents and heirs, executors and administrators; waiver and release Cleveland Performing Arts Ministries (CPAM) and Knight Sound & Lighting (KSL), their members, volunteers and sponsors from any and all claims for personal injuries, losses and damages I, or my minor dependents, may suffer or sustain by my or their participation in Tetelestai.

I understand that CPAM and KSL do not provide any medical insurance or care for its participants and that strobe lights and high levels of sound are used in the production of Tetelestai.

I understand that in the event of a medical emergency, reasonable attempts will be made to reach the parent/guardian of minors. If this fails, I hereby give my permission for representatives of CPAM to seek emergency medical treatment for any and all persons listed.

In case I/we are incapacitated, let each signature below and/or on the reverse side of this page, indicate that permission is given for medical treatment for any and all persons listed on this form.

MEDICAL INSURANCE INFORMATION *(This information MUST apply to all listed above)*

Name of **Insured** * ____________ Insurance Company ____________

Place of Employment ____________ Policy #, Class or Group ____________

CONTACT INFORMATION

*** Insured's:**

Home Phone ____________

Cell Phone ____________

Work Phone ____________

Emergency Contact:

Name ____________

Relationship ____________

Home Phone / Cell Phone ____________

INDIVIDUAL MEDICAL INFORMATION **** * MUST be completed and signed for EACH person listed above.***

*The information provided below will be used to provide assistance to medical personnel for your treatment in a medical emergency. It is **CONFIDENTIAL** and will be viewed ONLY by CPAM officers, Tetelestai Executive Director, KSL staff or appropriate medical personnel.*

Doctor's Name: ____________ First & Last Name: ____________

Doctor's Phone #: ____________ Date of Birth: ____________

Medical Conditions / Chronic Illnesses: ____________

Current Medications (include dosage): ____________

Allergic to these medications: ____________

Special Emergency Instructions: ____________

Signature of Adult or Parent/Guardian:	**Date:**

ADDITIONAL FAMILY MEMBERS ON BACK

INDIVIDUAL MEDICAL INFORMATION - CONTINUED

**** * MUST be completed and signed for EACH person listed above.***

The information provided below will be used to provide assistance to medical personnel for your treatment in a medical emergency. It is ***CONFIDENTIAL*** *and will be viewed ONLY by CPAM officers, Tetelestai Executive Director, KSL staff or appropriate medical personnel.*

Doctor's Name: ____________________ First & Last Name: ____________________
Doctor's Phone #: ____________________ Date of Birth: ____________________
Medical Conditions / Chronic Illnesses: ____________________
Current Medications (include dosage): ____________________
Allergic to these medications: ____________________
Special Emergency Instructions: ____________________

Signature of Adult or Parent/Guardian:	**Date:**

Doctor's Name: ____________________ First & Last Name: ____________________
Doctor's Phone #: ____________________ Date of Birth: ____________________
Medical Conditions / Chronic Illnesses: ____________________
Current Medications (include dosage): ____________________
Allergic to these medications: ____________________
Special Emergency Instructions: ____________________

Signature of Adult or Parent/Guardian:	**Date:**

Doctor's Name: ____________________ First & Last Name: ____________________
Doctor's Phone #: ____________________ Date of Birth: ____________________
Medical Conditions / Chronic Illnesses: ____________________
Current Medications (include dosage): ____________________
Allergic to these medications: ____________________
Special Emergency Instructions: ____________________

Signature of Adult or Parent/Guardian:	**Date:**