CLEVELAND PERFORMING ARTS MINISTRIES

LAST NAME: _____

EMERGENCY MEDICAL AUTHORIZATION (WAIVER) & MEDICAL INFORMATION FORM

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 spouse, my children 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, my spouse or my children 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:**