Calliope Youth Theatre Workshop Medical & Photo Release Forms

Name of Student: ______________________________________

Please Indicate any allergies or other medical issues that your child has, as well as any medications that he/she/they are taking:

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Emergency Contact Person: ____

Emergency Phone Number During Workshop Hours: __________________________

Primary Care Physician's Name: ____

Primary Care Physician's Phone Number: ________________________________

Health Insurance Provider: ____

Policy Number: _____________________

Please indicate any additional information about your child that we should know:

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I hereby grant permission for the staff of Calliope Productions to seek emergency medical treatment for my child during the Workshop Program.

Signed: ____ Date: ________________

(Note: The above information will be kept confidential, and this sheet will be destroyed after the Workshop is over)

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I hereby grant permission for Calliope Productions to use a photo or video of my child for promotional purposes related to this Workshop Program.

Signed: ____ Date: ________________