

THE DANCE INSTITUTE OF WASHINGTON

Medical Authorization Form

Section 1: Consent to Emergency Treatment

Student Name: _____

Purpose: To enable parents or guardians to authorize the provision of emergency treatment for children who become ill or injured while under the authority of The Dance Institute of Washington, when parents or guardians cannot be reached.

In the event of an emergency, please call:

1. Emergency Contact:

Name: _____

Relationship to child: _____

Contact Phone: _____

2. Emergency Contact:

Name: _____

Relationship to child: _____

Contact Phone: _____

In the event reasonable attempts to contact the above-mentioned have been unsuccessful, I hereby give my consent to transfer my child to:

Preferred Hospital: _____

Or any hospital reasonably accessible.

Child's Doctor: _____ Phone: _____

Signature of Parent or Legal Guardian: _____

Date: _____

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Section 2: Emergency Medical Information

Food Allergies: YES NO If yes, please list: _____

Medicine Allergies: YES NO If yes, please list: _____

Insect Allergies: YES NO If yes, please list: _____

Other Allergies: YES NO If yes, please list: _____

Is EPI-PEN required?: YES NO

Current Prescription Medications:

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Health Concerns: (Diabetes, Asthma, etc): _____