

THEATRE DE JEUNESSE EMERGENCY INFORMATION

Student's Name: _____

Mailing Address: _____

Birth Date: _____ Zip Code: _____

List two people to contact in case of emergency:

Parent / Guardian's Name: _____

Home Phone (including area code): () _____

Work Phone (including area code): () _____

Second person's name: _____

Relationship to Student: _____

Home Phone (including area code): () _____

Work Phone (including area code): () _____

Family physician's name: _____

Phone (including area code): () _____

Local hospital preference: _____

Are you allergic to any drugs? _____ If so, what? _____

Do you have any other allergies? (i.e. bee sting, dust) _____

Suffer from ___ asthma ___ diabetes, or ___ epilepsy? (Check any that apply)

Are you on any medication? _____ If so, what? _____

Please supply other emergency information we should know on back of form.

In case of a medical emergency I authorize the Theatre de Jeunesse staff to seek emergency medical aid for my student (circle one): YES NO

Parent/Guardian Signature: _____ Date: _____