



## Carlsbad Community Theatre Consent for Medical Treatment



In the event an actor is injured or an emergency occurs, CCT will make every effort to reach the parent or your emergency contact. If possible, CCT will call your designated doctor or dentist. However, if deemed necessary because of the nature of the injury or emergency, CCT will obtain treatment from the nearest hospital or call 911.

In the event of illness or injury, as actor/parent/guardian, I hereby give my consent for medical treatment. I give permission to a representative of CARLSBAD COMMUNITY THEATRE to provide or supervise on-site first aid for minor injuries and to a licensed physician to perform proper medical treatment. I agree to assume all costs related to any such treatment. I hereby authorize my insurance company to pay benefits for costs of such treatment.

Name of Actor: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any medical conditions, medications, or allergies we should be aware of: