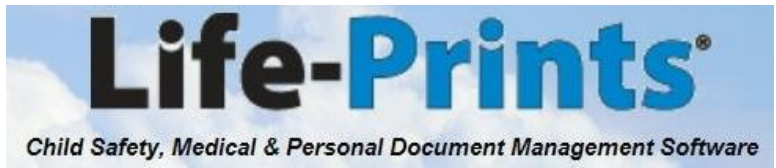


Child's  
Head Shot  
Photo  
Placement



Medical Authorization for Participation in: \_\_\_\_\_

Child Name \_\_\_\_\_ DOB \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Work Ph: (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact Number: (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Group No. \_\_\_\_\_

Policy/I.D. No.: \_\_\_\_\_

Alt Emergency Contact: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

**Medical Information**

Daily or regular use medications:

\_\_\_\_\_

\_\_\_\_\_

Allergies – include both personal and prescription medication allergies:

\_\_\_\_\_

\_\_\_\_\_

Medical conditions (i.e. diabetes, hypertension, seizures, hemophilia, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Date of most recent immunizations:**

Tetnus \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_

Rubella \_\_\_\_\_ Diphtheria \_\_\_\_\_ Polio Myelitis \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Contact Number: (\_\_\_\_\_) \_\_\_\_\_

Name of Dentist: \_\_\_\_\_

Contact number: (\_\_\_\_\_) \_\_\_\_\_

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

Date: \_\_\_\_\_