C.A.S.T. children's theatre

113 Summit Street ● PO Box 1268 ● Manchester, CT 06045-1268 ● (860) 649-5062 ● www.casttheatre.org

Permission and Medical Information Form

Please note that this form must be completed annually or when any information changes.
Students will not be able to participate in our classes/programs until this form is returned to us.

Student's Name _____ ☐ Male ☐ Female Age _____ Grade ____ Date of Birth _____

Mom's Name_____ Dad's Name_____ Guardian's Name_____

Street Address _____

Town _____ State _____ Zip _____

Student lives with: ☐ Mom ☐ Dad ☐ Both ☐ Guardian

Phone: Home _____ Student's Cell _____ Student's E-mail (if any) _____

Mom's Cell _____ Dad's Cell _____ Guardian's Cell (if applicable)_____

Mom's Work Phone_____ Dad's Work Phone_____ Guardian's Work Phone_____

Mom's E-mail Address_____ Dad's E-mail Address_____

Guardian's E-mail Address (if applicable)_____

Does your child have:

Yes	No	
☐	☐	Special Physical Needs?
☐	☐	Allergies?
☐	☐	Behavioral Problems?
☐	☐	Medical needs?
☐	☐	Current medication?

Are any of the following true: (if yes to any question, please explain on a separate page or below)

Yes	No	
☐	☐	There is a critical situation/important transition happening at home.
☐	☐	My child has been hospitalized within the last 3 years.
☐	☐	My child has been diagnosed with Attention Deficit / Hyperactivity Disorder (AD/HD).
☐	☐	My child has been diagnosed with Obsessive/Compulsive Disorder (OCD).
☐	☐	My child has been diagnosed with a learning or processing disorder.

Please list any medical concerns of which staff should be aware: (allergies, medical conditions, current medications, or physical limitations)_____

_____

Doctor's Name _____ Phone No. _____

Dentist's Name _____ Phone No. _____

Insurance Company or Medical Plan: Carrier:_____ #:_____

In the event of an emergency, **if a parent or guardian cannot be reached**, please list the name of a contact to be called other than the one listed above. **Every effort is made to reach a parent first.** This is only if we can not reach a parent.

Name _____ Relationship _____

Home Phone No. _____ Cell Phone No. _____

I give my son/daughter, _____, permission to participate in the class(es)/productions for which he or she is registered. My child may be photographed and/or videotaped during the course of the program. I understand that C.A.S.T. may use such images for archival or promotional purposes. In the event of an emergency during which I cannot be reached, I give permission to the bearer of this form to allow any doctor or medical facility to administer appropriate emergency procedures as may be necessary in the best interests of my child.

Parent Signature_____ Date: _____

Print Name_____