

# THE ACADEMY OF ARTS

## MEDICAL RELEASE & INSURANCE FORM

<b>Student's Name:</b>	<b>SS #:</b>
	<b>Cell Phone:</b> (   )
<b>Address:</b>	<b>Home Phone:</b> (   )

### TO WHOM IT MAY CONCERN:

Name of college student: \_\_\_\_\_

As a parent and/or guardian, I do hereby authorize treatment of the above student by any licensed physician in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment, or undue discomfort, if delayed.

The undersigned assumes the responsibility for any costs connected with such treatment and hereby releases **THE ACADEMY OF ARTS**, its' staff, or representatives liable for any injury sustained during any of **THE ACADEMY OF ARTS** activities.

Date or dates when release is intended: **September 6, 2009 – May 20, 2010 inclusive.**

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence. I hereby grant any **ACADEMY OF ARTS'** adult sponsor permission to obtain medical assistance and/or to hospitalize my child if it is deemed necessary.

I hereby release from liability for injuries to my son or daughter named above that may be incurred while he or she is in their care.

Signed: \_\_\_\_\_

Printed: \_\_\_\_\_

Father/Mother/Legal Guardian (Both parents must sign)

Address \_\_\_\_\_

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

Notary:

Name \_\_\_\_\_

Commission expires \_\_\_\_\_

Date \_\_\_\_\_

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### INSURANCE INFORMATION

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

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

ID Number: \_\_\_\_\_ Group No: \_\_\_\_\_

Policy or Plan number: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

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

Family physician \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

Date of last physical: \_\_\_\_\_

If you need documentation from **THE ACADEMY OF ARTS** regarding your child's enrollment in our college program, please let us know least three weeks in advance of the need.

**Please schedule a physical for your child to be completed before arrival.**

Specific medical allergies or other conditions \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Other contact in case of emergency \_\_\_\_\_ Phone (    ) \_\_\_\_\_

**Please complete and sign immediately and return by fax, email (as a PDF file),  
or regular mail by August 31, 2009.**

### **THE ACADEMY OF ARTS**

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Taylors, SC 29687

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Fax: 864.268.0351

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