

THE MOVEMENT BOX DANCE STUDIO, LLC. MEDICAL RELEASE FORM

I _____ (Name of parent/guardian) hereby give permission for any and all medical attention to be administered to my child _____ (child's name) in the event of accident, injury, sickness, etc. under the direction of the physician(s) listed below or at any necessary emergency facility, until such time as I may be contacted. I also assume responsibility for the payment of such treatment. This release is effective for the period of one year from the date given below.

ADDRESS _____
CITY _____ **ZIP CODE** _____

HOME PHONE _____
CELL PHONE _____
WORK PHONE _____ **EXT.** _____

INSURANCE COMPANY _____
POLICY NUMBER _____

STUDENT'S PHYSICIAN _____
ADDRESS _____
CITY _____ **ZIP CODE** _____ **PHONE** _____

KNOWN ALLERGIES _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

[Type text]