All Abilities Drama Camp, INC.
P.O.Box 141
Nicholasville, Ky 40340
www.allabilitiesdrama.com
aadramacamp@gmail.com

Medical Release Form (2019)

Parents/Guardians please fill out this form completely and sign where indicated. Thank you! (Please complete all parts that are applicable to you.)

Camper or Volunteer Name ____ Birth Date____/____/_____ Age____ F M
Home Address _________________________________City ______________________ State ____Zip_______
Grade in Fall 2019_______________________ School Currently Attending __________________________
Parent(s) or Guardian Name___________________________ (If under 18)
Parent(s) or Guardian or your E-Mail___________________________________
Home Phone _______________Business Phone ______________Cell 1_____________Cell 2______________
In case of Emergency please notify: ____
Phone_______________________________________Cell____________________Relationship:___________

My signature also authorizes the following people to pick my child up from camp if I am not able to:

Name: ____________________________ Name: ____________________________
Name: ____________________________ Name: ____________________________

THIS MUST BE COMPLETED FOR ATTENDANCE:
For Parent (if child) or adult volunteer to Sign:
Authorization for Medical Treatment: I hereby give permission to notify emergency medical services in the event of an emergency. I understand that I will be contacted immediately following the notification of emergency services. Furthermore, I understand that any medical cost incurred will be my responsibility. Authorization to attend All Abilities Drama Camp: I hereby give my permission for my child to attend All Abilities Drama Camp at Jessamine Early Learning Village.
Authorization for photographs and video taping: I hereby give my permission for All Abilities Drama Camp to photograph and/or videotape my child for promotional purposes.
Waiver: I waive and release any and all rights and claims I have against camp or its representatives for damages that may be sustained by my child.

Parent or adult volunteer Signature______________________________________ Date__________________

Family Physician:____ Phone_________________________
Family Dentist/Orthodontist_____________________________________ Phone_________________________
Is student covered by medical/hospital insurance? YES NO
Name of Insurance Carrier____
Policy Number____
Group Number______________________
Responsible Party____