Essence Studios
Dance & Performing Arts

Youth Emergency Medical Authorization

Name of Child: _____ Date of Birth: _____

Name of Parent(s)/Guardian: _____

Home Address: _____

Email: _____

Mother/Guardian Cell/Work: _____

Father/Guardian Cell/Work: _____

The Parent(s)/Guardian authorizes: the staff of Essence Studios to obtain immediate care and consents to the hospitalization of, the performance of necessary diagnostic test upon, the use of surgery on, and/or the administration of drugs to, his/her child or ward if an emergency occurs when he/she cannot be located immediately.

It is also understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise, he/she expects to be notified immediately.

☐ **I/We will be responsible for payment of medical care expenses.**

Medical treatment costs are covered by:

Name of Insurance Co.: _____ Policy #: _____

Child's Physician or Clinic: _____ Tel: _____

Child's Allergies (if any): _____

Outstanding Medical History (ex. Diabetes, Heart Diseases, etc.) _____

_____

Signature of Parent(s)/Guardian _____ Date: _____