School of Theatre & Music
College of Architecture,
Design, and the Arts
University of Illinois
at Chicago

1040 West Harrison Street
ETMSW Building
MC 255
Chicago, Illinois 60607

P 312 996 2977
F 312 996 0954
theatreandmusic.uic.edu

MEDICAL RELEASE FORM

STUDENT INFORMATION

NAME _____

DATE OF BIRTH_____GENDER_____

IN CASE OF EMERGENCY CONTACT

NAME/RELATIONSHIP _____

EMERGENCY PHONE NUMBER (_____)_____

In case of a medical emergency, if you feel the staff should know of any particular medical condition, please disclose that here. This health information may be the only source of accurate important information. Whatever is disclosed will be held in strict confidentiality. You do NOT need to disclose anything if you do not wish to.

_____

_____

INSURANCE INFORMATION

FAMILY DOCTOR NAME_____

CLINIC/HOSPITAL NAME _____

FAMILY DOCTOR OFFICE PHONE_____

INSURANCE PROVIDER NAME_____

NAME OF POLICY HOLDER _____

POLICY NUMBER_____GROUP NUMBER _____

I understand that if a serious illness/injury develops, the emergency contact will be contacted and medical or hospital care will be sought. If it is is not possible for the emergency contact to be reached, I give my permission for the release of insurance and medical information as well as any medical treatment recommended by the attending physician. I will assume responsibility for any medical bills incurred. The health care provider may release information to the insurance company.

SIGNATURE (Parent or Guardian) _____

Date: _____

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