



Fayette County Community Theatre

"Building Community Through Play"

MS/HS Summer Workshop Medical Release Form

This form must be completed and returned to the Workshop Director prior to the program start date.

Personal Information

Student's Last Name _____ FirstName _____

Birthdate _____ Circle one: M F

Address _____ City _____ State _____

Zip _____

Home Phone _____

E-mail Address _____

Parent/Guardian 1 _____ Daytime Phone _____

Parent/Guardian 2 _____ Daytime Phone _____

Health Insurance Carrier _____ Policy Number _____

Plan Number _____

Family Physician _____ Phone _____

If neither parent nor guardian is available in an emergency, please contact:

1. _____ Phone _____

2. _____ Phone _____

Health History

Allergies:

Date of most recent tetanus immunization: _____

Please list any major past illnesses (contagious and non-contagious):

Please list any major operations or serious injuries (include dates):

Has the youth ever been hospitalized? No Yes

Does the youth have any chronic or recurring illness? No Yes



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Is there anything else in youth's health history that the workshop staff should know?

Are there any activities from which the youth should be restricted? No Yes

Does the youth have any special dietary restrictions? No Yes

If YES, explain:

Does the youth wear any medical appliances (glasses, contact lenses, orthodonture, etc.)? No Yes

If YES, explain:

Is the youth's immunization record current showing that the youth has been immunized in accordance with the Texas Department of State: No Yes

Health Services Minimum State Vaccine Requirements? No Yes

If No, attach official documentation of TDHS exemption from immunizations for Reasons of Conscience or a Physician's Statement of medical contraindications.

This authorizes physicians, medical personnel and workshop sponsors to release information concerning the medical status, medical condition, injuries, prognosis, diagnosis and related personally identifiable health information of _____ (participant name) to workshop staff. This information includes injuries or illnesses relevant to participation in the above named workshop at the Fayette County Community Theatre.

SIGNATURE OF STUDENT

DATE

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE

Will the youth need to take any medication at the workshop? No Yes

If YES, please list the specific prescription or over-the-counter medications below, reasons for medication, and daily dosage.



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Medication Reason(s) for Medication Daily Dosage/Time(s) Taken

The Fayette County Community Theatre CAMP PLAY designated personnel will not dispense non-prescription or prescription medication to the above named participant until the following information has been completed by a parent or guardian. It is the responsibility of the parent/guardian to give the medication directly to the workshop director or designated staff member in individual dosage containers, original prescriptions containers, or envelopes clearly labeled with dosage instructions on the first day of the workshop.

I _____, the parent/guardian of
_____ give permission to the staff of the FCCT Camp Play to administer the prescription medications listed above.

My child may possess and self-administer the following medicine:

and I affirm that my child understands and agrees that he/she will use the medication only according to dosage instructions, and will not share or otherwise provide medication to any other person while at the workshop, and failure to do so is a violation of workshop rules that will result in disciplinary action, up to and including removal from the program.

I hereby release the Fayette County Community Theatre, its Board of Directors, officers, employees, and representatives from any and all liability in any way resulting or arising from the administering of the above medication.

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE

I, the undersigned, as the parent or legal guardian of _____ (a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending provider, appropriate staff, and the Fayette County Community Theatre and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical, and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.



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PRINT NAME

I have received a copy of University Health Services Notice of Privacy Practices as required by HIPAA Privacy Rules. The Fayette County Community Theatre honors the privacy of the participants in its programs and complies with the national regulations regarding health information.

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE

Please Return to Workshop Director:

Name of Program: Fayette County Community Theatre CAMP PLAY

Camp Director: Melissa Weltner

FCCT Phone: 979-702-9368

FCCT Mailing Address: P O Box 697, La Grange, TX, 78945