MEDICAL RELEASE FORM

As the parent/legal guardian of _____I hereby authorize The Art Effect and appointed staff thereof to admit, during my absence, the above-named student to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named student.

Student's DOB | Gender

Any known allergies? ☐ yes ☐ no

If yes, please specify

Any other medical conditions which should be noted? ☐ yes ☐ no

If yes, please specify

Currently taking medications? ☐ yes ☐ no

If yes, please specify

Family Physician | Physician's Phone

Insurance Provider | Policy #

Alternate Contact (in case parent/guardian is not available)

Relation to Student | Phone Number

Name of Parent/Guardian | Parent/Guardian's Emergency Phone# Cell

Home/Office Phone #

Signature | Date

THE ART EFFECT
FORMERLY MILL STREET LOFT + SPARK MEDIA PROJECT

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