**Richardson Fine Arts Conservatory (RFAC)**
**MEDICAL EMERGENCY CONTACT FORM**

As participant and/or legal guardian, I hereby authorize any agent of Richardson Fine Arts Conservatory (RFAC) or Toby's School of Dance to seek and authorize emergency medical treatment for myself or underage participant when it is deemed necessary by the agent responsible. I fully understand that every effort will be made to contact the legal guardian or designated agent as soon as possible, giving first priority to the participant's emergency care. I further understand that I am responsible for any and all charges as a result of such care or medical treatment.

This authorization does not cover major surgery unless medical opinions of two licensed physicians that concur in the necessity and urgent nature for such surgeries are obtained prior to the performance of such surgery.

***Included with this form is a copy of my Insurance Card (Front and Back) for medical treatment purposes***

Participant's Signature ______ Date ______ Participant's Printed Name ______ Age ______

Parent/Guardian Signature ______ Date ______ Parent/Guardian Printed Name ______
*(if participant is under 18)*

## Participant Information

Name ______ Date of Birth ______ Age as of 9/1/2017 ______

Parent/ Guardian ______ Relation ______ Cell ______

Primary Physician ______ Office Phone ______

Insurance Carrier ______ Policy #/ Group # ______

Name of Policy Holder/Insured ______

## Emergency Contact

Name ______ Relationship ______

Home Phone ______ Cell ______ Work ______

Email ______ Address ______

City ______ State ______ ZIP ______

## Secondary Emergency Contact

In the event that a parent/guardian/designated agent cannot be reached right away, I would like you to try and call the following people who will know how to contact me. (In order of preference)

Name ______________________ Relation ______________ Phone ______________

Name ______________________ Relation ______________ Phone ______________

Name ______________________ Relation ______________ Phone ______________

## Participant's Health History

Medications

Drug Allergies/ Reaction

Food Allergies/ Reaction

Allergic Reaction Action Plan

Previous Hospitalizations With Dates/ Reasons

Surgeries

- ❑ Asthma
- ❑ Fracture/Sprain
- ❑ Anemia
- ❑ Diabetes
- ❑ Scoliosis
- ❑ Vitamin Deficiencies
- ❑ Heart Murmur
- ❑ Pins/Rods
- ❑ Migraines
- ❑ Nose Bleeds
- ❑ Hernia
- ❑ Current Injuries
- ❑ Autoimmune Condition
- ❑ Bone Fusions
- ❑ Anomalies

Other/Further Explanation (if necessary)

Participant Limitations Which Would Affect Participation