

**LEXINGTON YOUTH THEATRE MEDICAL EMERGENCY INFORMATION  
FORM**

Name of Production \_\_\_\_\_

**CAST MEMBER  
NAME:** \_\_\_\_\_

**PARENT/GUARDIAN  
NAME:** \_\_\_\_\_

**IF I CANNOT BE REACHED, IN THE EVENT OF AN EMERGENCY CALL:**

**NAME** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**RELATIONSHIP TO  
CHILD** \_\_\_\_\_

**PERSONAL PHYSICIAN NAME** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**Please list any food allergies or special  
needs:** \_\_\_\_\_

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**In the event of a medical emergency, I hereby authorize Lexington Youth  
Theatre and it's representatives to secure emergency medical treatment for  
my child, \_\_\_\_\_ (child's name).**

**Signature of  
parent/guardian** \_\_\_\_\_

**Printed name of  
parent/guardian** \_\_\_\_\_

**Date:** \_\_\_\_\_