

Lexington Youth Theatre

Contact Information/Medical Emergency

Name of Production _____

Cast Member Name: _____ Primary Phone: _____

Address: _____ Cell # (actor) _____

City: _____ St.: _____ Zip: _____

Email Cast Member: _____

School Attending: _____ Grade _____ Age _____ M/F _____ Ht. _____ Birthdate _____

Parent's Name to contact about LYT information during practice and performance times.

Parent/Guardian Name _____ Phone _____ Cell _____

Parent/Guardian Email _____

EMERGENCY CONTACT

(If parent cannot be reached, in the event of an emergency)

Name: _____ Phone #: _____

Relationship to child _____

Physician's Name: _____ Phone #: _____

Please list any food allergies or special needs: _____

In the event of a medical emergency, I hereby authorize Lexington Youth Theatre and its representatives to secure emergency medical treatment for my child, _____
(child's name)

Signature of Parent/Guardian: _____

Printed Name of Parent/Guardian: _____ Date: _____