

# STUDIO MAESTRO

## 2008 Medical Information form



Please return this form along with a copy of your health insurance/prescription plan card.

### Student Information:

Student name: \_\_\_\_\_

Age: \_\_\_\_\_ D.O.B \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ S.S# \_\_\_\_\_  
*Month Day Year*

Address: \_\_\_\_\_  
\_\_\_\_\_

Insurance Company: \_\_\_\_\_

Phone: \_\_\_\_\_

Policy #: \_\_\_\_\_

Address: \_\_\_\_\_

Name of policy holder: \_\_\_\_\_

Policy holder Social Security: \_\_\_\_\_

2nd Insurance Company: \_\_\_\_\_

Phone: \_\_\_\_\_

Policy #: \_\_\_\_\_

Address: \_\_\_\_\_

Name of policy holder: \_\_\_\_\_

Policy holder Social Security: \_\_\_\_\_

***Medical History***

Student Name: \_\_\_\_\_

Student's Physician: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Please list all existing medical conditions including known allergies or medications the student cannot take:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all existing prescriptions the student is currently taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

***IN CASE OF EMERGENCY PLEASE CONTACT:***

Name: \_\_\_\_\_

Telephone: Day \_\_\_\_\_ Eve: \_\_\_\_\_

Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

2nd emergency contact: \_\_\_\_\_

Telephone (Day): \_\_\_\_\_ Eve: \_\_\_\_\_

Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

# HEALTHCARE/POWER OF ATTORNEY 2008

Student Name: \_\_\_\_\_

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

CITY OF \_\_\_\_\_

In an emergency when parental permission is not available:

I, \_\_\_\_\_, esq., being duly sworn, deposes and says  
Parent or Guardian

that I am the guardian of \_\_\_\_\_. I hereby designate a staff member of  
Student's name

Studio Maestro, (212) 787-1178, to authorize any and all medical care and treatment that may  
be needed by \_\_\_\_\_ during the following weeks of attendance.  
Student's name

**Please check off the dates of attendance**

- Week 1: August 4-August 10, 2008       Week 3: August 18-August 24, 2008  
 Week 2: August 11-August 17, 2008       Week 4: August 25-August 31, 2008

I agree to be responsible for any medical fees incurred in connection with any such medical care and treatment.

Sworn and subscribed to me this the \_\_\_\_\_ day of \_\_\_\_\_, 2008

\_\_\_\_\_  
Signature of Parent or Guardian

Notary Public

County of \_\_\_\_\_, State of \_\_\_\_\_

My commission expires

**Please note: We will not accept any student who is under 18 into the Summer Program until this form is completed, along with a copy of the insurance plan card.**