## Authorization to Consent to Medical Treatment

I (We), the undersigned, do hereby authorize representatives of Theatre Arlington (such representatives to be employees, directors, Auxiliary members or identified volunteers) to serve as agents for the undersigned to consent to any X-ray exam, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or specific supervision of any physician or surgeon licensed by the State of Texas whether such diagnosis or treatment is rendered at the office of said physician or at said hospital or some other site.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem available.

I (We) also understand and agree Theatre Arlington will not be held responsible for injuries that occur to self/child while attending or participating in any Theatre Arlington function.

This authorization shall remain valid for the duration of the participant's current registration with Theatre Arlington.

**IN CASE OF EMERGENCY**

Name of Participant:

Insurance Co.: Policy #:

Policy Holder Name & Phone:

Any known allergies or medical problems?:

**Signature, parent or guardian** **Date**

I DO NOT authorize Theatre Arlington to serve as an agent to seek medical treatment for my child.

Signature, parent or guardian if under 18 Date