

IN THE LIMELIGHT
Medical & Photo Release Form

The undersigned, who is the parent/legal guardian of _____

NAME OF ACTOR

a minor (hereinafter referred to as "Student"), on behalf of himself/herself and Student, their personal representative, assigns, heirs and next of kin.

1. Hereby releases, waives, discharges and covenants not to sue **IN THE LIMELIGHT**, their officers, employees and agents, all for purposes herein referred to as the Theatre, from all liability, to the undersigned and Student, their personal representatives, assigns, heirs and next of kin, for all loss or damage and/or claims, demands, causes of actions or suits of any kind therefore, particularly on accounts of injury to the person or property or resulting in the death of Student, while Student is a participant;

2. Hereby agrees to indemnify and save and hold harmless the Theatre from any loss, liability, damage, or cost they may incur while Student is a participant;

3. Hereby assumes full responsibility for and risk of bodily injury, death or property damage while Student is a participant;

4. Hereby agrees that if any portion of the Agreement is held invalid, that the balance shall, notwithstanding, continue in full legal force and effect.

5. I grant **IN THE LIMELIGHT** permission to photograph, record, or otherwise secure images of myself or my child. In addition, I hereby permit **IN THE LIMELIGHT** to use these images and publish in print, electronic or video format these likenesses. I release all claims against In the Limelight with respect to copyright ownership and publication including any claim for compensation related to the use of these materials.

Signature of Parent/ Legal Guardian

Month/Day/Year

MEDICAL INFORMATION

In the event Student becomes ill, I authorize the IN THE LIMELIGHT directors and/or instructors to obtain medical attention at a physician's office or hospital. Student is covered by the following medical insurance:

Insurance Co. Name _____ Group# _____

Insurance Co. Address _____ Insurance Co. Phone _____

Allergies _____ Chronic/Acute Illnesses _____

Pediatrician's Name: _____ Phone: _____

Orthodontist's Name: _____ Phone: _____

I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO REACH ME BEFORE MEDICAL PERMISSION IS GIVEN TO MY CHILD.

Home Phone: _____

Signature of Parent/Legal Guardian

Work Phone: _____

Date

Cell Phone: _____