

Lake Charles Civic Ballet

Volunteer Medical/Release Form

Volunteer Name: _____

Telephone # _____

Insurance/medical information:

Primary insured's name: _____

Insurance Carrier: _____

Policy # _____ Telephone # _____

My Physician's name _____ Telephone # _____

I am allergic to _____

Current medications, dosages, and frequency: _____

Other information that LCCB staff may need to know about my medical history:

Emergency Point of Contact:

Name: _____

(H) _____ (W) _____ (C) _____

Relationship to Volunteer: _____

LCCB has my permission to obtain medical help for me.

Volunteer printed name _____

Volunteer signature _____

Date _____

Lady Leah Lafargue School of the Dance/Lake Charles Civic Ballet has my permission to use my image/likeness for promotional purposes including, but not limited to advertising items, official website, and social media.

Volunteer signature _____

Date _____