



CNY Jazz Arts Institute Student Medical Release

I authorize emergency medical or surgical care to be given to my child when I am unable to be reached or contacted in an emergency. This authorization includes treatment which the examining physician feels he/she can skillfully provide and/or referral to other medical centers or physicians when the examining physician determines that such referral is indicated.

Name of Student (please print): _____

Signature of Parent/Guardian: _____

(please print name here)

Phone (day): _____

Phone (eve): _____

Phone (cell): _____

Other: _____