



National  
Cello  
Institute

**MEDICAL RELEASE FORM TO BE SIGNED BY PARENT/GUARDIAN**

**EMERGENCY CONTACT INFORMATION FOR (child's name):** \_\_\_\_\_

Person(s) to contact \_\_\_\_\_

Relation to Child \_\_\_\_\_

Emergency Phone Numbers \_\_\_\_\_

**INSURANCE POLICY INFORMATION**

The above-named child is covered by health insurance (please circle one): YES or NO

If yes, provide the following information, which is required by Pomona College and the National Cello Institute to expedite treatment

Policy Holder's Relation to Child \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

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

Policy # \_\_\_\_\_ Plan # \_\_\_\_\_

**MEDICAL TREATMENT CONSENT**

Should my child, \_\_\_\_\_, require medical attention and/or care while participating in the **National Cello Institute (NCI)** at Pomona College, I give my consent to Pomona College and NCI staff to obtain such medical attention and/or care.

I also give my consent to any X-ray examination (or similar examination such as by CAT scan), anesthetic, medical or surgical diagnosis or treatment and hospital care as may be determined by the attending physician.

Should an emergency arise requiring major surgical procedures and I cannot be contacted, the attending physician has my consent to act as that physician's medical judgment may dictate. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, that it is given to provide Pomona College and NCI staff authority to seek medical treatment, and that it will remain in effect for the duration of the NCI.

I accept responsibility for payment of all services rendered; I authorize any medical facility, which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand and agree that both I and my child, and each of our respective personal representatives, heirs, executors, administrators, agents, and assigns, forever release Pomona College, NCI and their employees and staff, from all claims, damages, actions or causes of action which may occur as a result of any decisions they make concerning the emergency care or treatment of my child. I also understand that any decisions made by Pomona College or NCI employees or staff will be guided by the best interests of my child.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date