

OLD STURBRIDGE VILLAGE

PROGRAM PARTICIPANT MEDICAL INFORMATION AND RELEASE FORM

Program Title _____ Program Date _____

Please return this form to the address below at least 3 weeks prior to the program date.

Child's Name _____ Date of Birth _____ Gender M F

Address _____

Town _____ State _____ ZIP _____

Home Telephone (include area code) (_____) _____

Where parents/guardians can be reached during program if not at home address:

Name _____ Daytime Phone (_____) _____

Cell Phone (_____) _____

Address _____

Name _____ Daytime Phone (_____) _____

Cell Phone (_____) _____

Address _____

In case of accident or serious illness, we request that Old Sturbridge Village contact us. If we cannot be reached, we hereby authorize the Village to call the physician below and follow his/her instructions. If impossible to contact this physician, the Village may make whatever arrangements seem necessary. We understand that employees of Old Sturbridge Village are not licensed to distribute or administer medication.

Physician's Name _____ Telephone Number (_____) _____

Address _____

Please include any information about your child that you think will be helpful to us (i.e., allergies, physical or learning disabilities, or other considerations).

We hereby give our permission for our child named above to participate in the full range of this program's activities. We understand that Old Sturbridge Village is not responsible in the event of accident or illness. We also consent to the use for publication of photographs taken by Old Sturbridge Village or news photographers and any written materials or work produced by our child.

(Date)

(Signature of Parents or Guardians)

Please return to: **Education Building
Old Sturbridge Village
1 Old Sturbridge Village Road
Sturbridge, MA 01566**

