

Summer Studio Medical Release Form

This form is to be completed by ALL workshop participants and returned to The Art Institute of Ohio — Cincinnati.
All information is strictly confidential and will be used only in case of emergencies.

MEDICAL INFORMATION:

Name Of Participant: _____

Please list any known allergies to foods: _____

Insurance Provider: _____ Policy #: _____ Group #: _____

Name of Policy Holder: _____

Insurance Provider Phone Number: _____

Insurance Provider Address: _____

CONTACT INFORMATION FOR PARENT OR LEGAL GUARDIAN:

Name of Parent or Guardian: _____

Home Phone: () _____ Work Phone: () _____

If parent cannot be reached by phone, please contact:

Name: _____ Phone: () _____

See aiprograms.info for program duration, tuition, fees, and other costs, median debt, federal salary data, alumni success, and other important info.