

SPROG INC. MEDICAL AUTHORIZATION FORM

Must complete ALL sections on this form

Participant Name _____
Last Name First Name M.I.

Child's Physician _____ Phone # _____

Child's Dentist _____ Phone # _____

As the parent/guardian, I understand that in case of an emergency, SPROG will first attempt to contact me. I understand that if I cannot be reached, the emergency contact person (included on Registration Form), or the physician will be called. In case of a critical emergency, I would prefer, if possible, that my child be taken to _____ Hospital via ambulance. I will accept full financial responsibility for charges connected with the use of an ambulance, if necessary, and any charges connected with care at the hospital.

MEDICATION REQUIREMENT

I understand that all prescription medication **must** be in the original container and labeled with my child's name. I further understand that the instructions, including times, amounts for dosages and Physician's name should be included on the medication. I authorize an adult employee of SPROG to administer any such medication to my child.

Medications my child will be taking that require administering while at SPROG are:

KNOWN ALLERGIES/HEALTH CONCERNS:

My child has the following allergies _____

My child has the following medical concerns that SPROG should be aware of:

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____ Date _____



***SPROG IS PEANUT/NUT FREE DUE TO SENSITIVITY/ALLERGIES**