MEDICAL CONSENT AND PERMISSION TO TREAT

To the best of my knowledge, my child, _____, is in good health, and I assume all responsibility for the health of my child. **Emergency Medical Treatments:** In the event of an emergency, I hereby grant permission to transport my child to a hospital for emergency medical treatment.)_____**YES** _____**NO** I wish to be advised prior to any further treatment by the hospital or doctor._____**YES** _____**NO**

Parent/Guardian's Name:_____
Home Address:_____
Home Phone: (_____) _____ Business Phone: (_____) _____
Cell Phone: (_____) _____

If you are unable to reach me, please contact:
Name:_____
Relationship to me or my child:_____
Home Phone: (_____)_____ Business Phone: (_____) _____
Cell Phone: (_____) _____

Family Doctor:_____
Phone Number: (_____) _____

Please include a photocopy of your Insurance Card (front and back).

- Insurance Carrier:_____ Policy Number_____
- My child is taking medication and will bring all medication with him/her. It will be clearly labeled. My child is taking the following medication(s) and directions for taking this medication, including dosage, frequency and storage are as follows:_____
  _____
- I hereby grant permission for non-prescription medication (such as cough drops, cough syrup, Tylenol, etc.) to be given to my child if necessary:_____**YES** _____**NO**
- I understand that aspirin will not be given to my child without my express permission. I hereby grant such permission:_____**YES** _____**NO**
- My child is allergic to the following (medications, foods, plants, insects…etc.)_____
- My child's immunizations are current and up to date:_____**YES** _____**NO**
- My child's last tetanus/diphtheria immunization: _____
- My child has the following physical limitations: _____
- My child experiences homesickness, emotional reactions to new situations, sleepwalking, fainting, bed wetting, etc. _____**YES** _____**NO**. If Yes, please explain:_____
  _____
- My child has recently been exposed to a contagious disease or condition such as mumps, measles, chickenpox, etc. _____**YES** _____**NO**. If Yes, please state the date and disease or condition:
  _____
- My child is suffering from a psychological condition which may affect or limit his or her ability to participate in this activity. _____**YES** _____**NO** If Yes, please explain:_____
  _____.

_____ _____

Signature of Parent or Guardian **Date**