

MEDICAL INFORMATION AND CONSENT FORM

School/City_____

Participant's Name_____ Date of Birth_____

Parent/Guardian Name_____

Address_____

City/State/Zip_____

Home Phone_____ Work Phone_____

Emergency Contact (if parent/guardian cannot be reached):

Name_____ Phone_____

Physician's Name_____ Phone_____

Medical Information:

1. Does the participant take medications regularly? ____Yes ____No
If yes, describe:_____
2. Does the participant have any allergies or chronic illnesses? ____Yes ____No
If yes, describe:_____
3. Is the participant allergic to any drugs or medications? ____Yes ____No
If yes, describe:_____

In the event that my child,_____, requires emergency medical treatment due to illness or injury, I hereby give my consent to the following:

1. personnel supervising my child to arrange for emergency medical care at an appropriate medical facility:
2. medical personnel at the medical facility to render necessary treatment to my child.

I further acknowledge and agree that I will assume responsibility for payment of all expenses associated with the medical care above described.

Parent/Guardian_____

Date_____