NEW BALTIMORE SUMMER RECREATION MEDICAL RELEASE FORM

NAME_____

AGE_____ D.O.B. _____PHONE #_____

PARENT/GUARDIAN NAME _____

BUSINESS OR CELL PHONE _____

MEDICAL INSURANCE CO. _____

POLICY # _____

PERSON TO CONTACT IF YOU CANNOT BE REACHED

1) _____TEL# _____

2) _____TEL# _____

Health Information: List any health conditions such as heart disease, diabetes, seizures, bee sting allergy, asthma, etc. _____

How is the above condition treated, or what would you like us to do?

_____

Medication allergy (names)_____

ALLERGIES: _____

MEDICATIONS: _____

Name of medication (prescribed or over the counter) your child will be bringing.

_____

*FOR A DAY TRIP - ONLY MEDICATIONS THAT ARE ABSOLUTELY NECESSARY SHOULD BE CARRIED.

All medications have to be in the original bottle, container or box, and child's name should be written on it(no loose medication please, since we need to be able to identify what the child is carrying).

Do you give permission for your child to carry his/her medication? Yes ___ No ____ If you checked no, who do you designate to give your child's medication? Name of person _____

If medications are listed above, I attest that my child has been instructed in, understands the purpose, appropriate method of use, and frequency of the medication. I consider him/her responsible as indicated by my signature below.

.....

I, _____ parent/guardian of the above named child give my permission to attend the attached town park sponsored trip, and to use the above medications (if listed).

I also grant the release of my child's name and photo for directory and /or news releases.

In the event of injury or accident, if I cannot be present for emergency treatment, I hearby authorize the administration of first aid or medical diagnostics under the advisement of any of the adult chaperones.

Signature: _____ Date: _____