Allergies/Medical Conditions

ALLERGIES: Please list all known allergies, including how the child has been treated and with what medication(s).

_____
_____
_____

MEDICAL CONDITIONS: I hereby warrant that, to the best of my knowledge, my child is in good health and able to participate in all program activities. Please list all known medical conditions including limitations and /or conditions of which we should be aware of.

_____
_____
_____

AUTHORIZATION FOR MEDICAL TREATMENT: I herby authorize the treatment, administration of anesthesia, and surgical treatment form my minor daughter/son (child's name)_____ in the event of a medical situation occurring during my absence or when the hospital or physician(s) and nursing personnel within the physician's staff where treatment is rendered in the physician's office. I release from medical responsibility and liability, the hospital, physician(s), and nursing personnel for performing medical procedures acting on the authority of this medical treatment consent form which such medical providers deem necessary for my minor child.

PHYSICIAN/INSURANCE INFORMATION

Physician:_____ Address:_____
Phone Number:_____

Family Health Insurance Co._____Policy No._____

Health Ins Address_____
Health Ins Phone #_____

ADDITIONAL INFORMATION IF APPLICABLE:

_____
_____
_____
_____