

Emergency Permission Form

Name of participant _____ Age _____ DOB _____

I hereby give my permission for my son/daughter to have an x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care in the case of an emergency. I understand that this will be done only by or at the order of a qualified physician and in the best judgment of a staff member or instructor, when the need for such treatment is immediate and when all efforts to contact me are unsuccessful.

Parent/guardian Signature _____ Date _____

Address _____ City _____ State _____ Zip _____

Parent 1 Name _____

Cell _____ Home _____ Work _____

Parent 2 Name _____

Cell _____ Home _____ Work _____

Medical Insurance Carrier _____

Subscriber's Name _____ Policy # _____

Child's Doctor/Office _____ Phone _____

Child's Allergies _____ Glasses/contacts _____

Medications child is taking _____

Medical conditions/history _____

Do you give permission for you're child to receive Tylenol? Circle one: YES NO

Do you give permission for you're child to receive Benedryl? YES NO

Do you give permission for you're child to receive allergy eyedrops? (I.e. Visine) YES NO

Parent Signature _____ Print _____

If your child becomes ill and needs to leave and you cannot be reached, please list the names of 2 people willing to take responsibility until you can be reached.

Name _____ Phone _____ Relationship _____

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