**SUMMER ACTIVITIES MEDICAL FORM**

Student Name: Date of Birth:

Address: Personal Doctor:

 Phone:

Parent/Guardian Name:

Contact Numbers: (H) (W) (C)

Parent/Guardian Name:

Contact Numbers: (H) (W) (C)

Insurance Information:

 Insurer Policy # Group #

Allergies: Drug (list)

 Food (list)

 Insect (list)

 Other (list)

Medications:

 Name: Dose: Time to Be Given:

 Name: Dose: Time to Be Given:

 Name: Dose: Time to Be Given:

 Special Instructions:

 My child will keep the medication and is responsible to take his/her own medication. I am aware that these medications may not be shared with anyone.

 Student Signature

 I prefer that will keep and administer said medication to my child per the directions listed above. (Medication should be signed off with date, time and initials when given.)

In the event I cannot be reached, I hereby give my permission for my child to be transported to the nearest hospital. I authorize emergency treatment. I will assume full responsibility for all charges incurred for emergency treatment.

 Parent Signature Date