Camp Iwannahavefun!

AUTHORIZATION FOR MEDICAL INFORMATION

Child's Name_____ Birthdate_____

Address_____ Phone_____

Allergies to Food_____

Allergies to Medication_____

Other Allergies_____

List of medications currently taking_____

My child has the following medical/behavioral conditions_____
(Please give a brief description)

Family Doctor_____ Phone_____

Family Dentist_____Phone_____

EMERGENCY MEDICAL CARE

First aid will be administered by the Park District Staff for bumps, bruises, cuts, scratches, splinters and/or nose bleeds.

In case of a serious medical emergency and we are unable to contact you, the parent or guardian, or your other emergency contacts, we need your permission to have your child treated. We will make every effort to contact you before taking any action, but if emergency room or hospital care is required, this permission is required. Your child will be taken to Hinsdale Hospital unless otherwise indicated.

This authorizes the Darien Park District staff to secure emergency medical care for my child when I/we cannot be immediately reached at the time of the emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement.

_____ _____ _____
Parent/Guardian Signature Phone Date

_____
Relationship to child