After School Enrichment Program

**MEDICAL RELEASE**

**Note**: To be submitted prior to being enrolled in the program.

****Please complete ONE per student****

Child's Name: _____ Date of Birth: _____Gender (M/F) ____

Parent/Guardian Name: _____ Relationship: _____

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Child's Address: _____ City: _____ State ____ Zip _____

Home Phone: _____Work: _____

Mobile: _____Email:_____

**PARENT OR GUARDIAN AUTHORIZATION**:

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, ER Physician)

Family Physician: _____ Phone: _____

Address: _____City: _____ State _____

Hospital Preference: _____

Parent Insurance Co. _____ Policy # _____ Group ID_____

If parent(s)/guardian cannot be reached in case of emergency, contact:

1. _____
   Name/Phone/Relationship to Child

2. _____
   Name/Phone/Relationship to Child

Please list any allergies/medical problems, including those requiring maintenance medications. (i.e., Diabetic, Asthma, Seizure Disorder)

| |
|---|
| Medical Diagnosis: |
| Medication: |
| Dosage: |
| Frequency of Dosage: |
| Date of last Tetanus Booster: |

***The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Mr./Mrs./Ms.

_____Date: _____

Authorized Parent/Guardian Signature