Permission Form for Medical Treatment

(Please print or type all information and attach a copy of both sides of your insurance card.)

Name _____ Birth Date _____ SS# _____

I, the undersigned, being the parent or legal guardian of the person named above, hereby authorize any necessary medical treatment for this person while participating in any **FUN FARM CENTER** activities. I guarantee payment of all charges incurred during this medical treatment (physician, hospital, X-ray, lab, medications, ambulance, etc.). I also give permission for the staff or chaperones accompanying the students to administer first aid. I also give my permission for the person named above to participate in all activities**,** agreeing to support and to encourage the student named above to adhere to the policies and rules of the program.

1. Allergies to food, medications, etc. (If none, so state.)_____

2. Allergies to insect bites and stings. Please describe student's reaction and medicine taken. (If none, so state.)_____

3. Special medical problems (If none, so state.) _____

4. Medication taken regularly (If none, so state.)
   Medicine _____ Purpose _____
   Medicine _____ Purpose _____

5. Date of last tetanus shot _____

6. Family Physician _____ Phone _____

   **Hospital of preference _____

Name of parents _____

Parent's address _____

City _____ State _____ Zip _____ Phone _____

Father's Work Phone _____ Mother's Work Phone____ _____
Father's Cell Phone _____ Mother's Cell Phone _____

Name of person(s) if parents cannot be reached _____

Relationship _____ Phone _____
Relationship _____ Phone _____

I hereby waive and release the school and staff from any liability for any injuries sustained while at school. I also certify he/she is physically fit to take part in all school activities.

Parent's Signature _____Date_____

Copy of Insurance Card _____