



P.A.R.K.

Positive Atmosphere Reaches Kids

Medical Information/Medical Authorization

Student's Name _____

Prescribed medication to be taken must be in a prescription container labeled with student and doctors names, along with direction for dosage.

1. _____
2. _____
3. _____

Please list all over the counter medicine (Asprin, Tylenol, etc) _____

List all Allergies: Penicillin, Hay Fever, Poison Ivy/Oak, Insect bites, Foods, etc.

I give permission for my child, _____ to take medication listed above, to be administered by PARK staff. I understand that I must provide all medication with directions to PARK.

Parent/Guardian Signature: _____

Date: _____

Medical Authorization

I hereby give my permission to medical personnel selected by the PARK program's Program Director to order X-rays, routine tests and treatment for my child if he/she becomes ill or injured, and in the event I can not be reached in an emergency. I hereby give permission to the physician selected by the PARK program's Program Director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named her. This form may be photocopied for use off the grounds of PARK for PARK events.

Child's Name _____ Date _____

Parent/Guardian Signature _____ Date _____

Emergency Contact _____ Telephone _____

Doctor's Name _____ Telephone # _____

Hospital _____

Medical History/Hospitalization _____

Do you have any medical insurance/Medicaid or Medicare _____ Yes _____ No

Name of Insurance Carrier: _____ Policy # _____

Medicaid # _____