

# MEDICAL TREATMENT FORM

## NORTH CASTLE RECREATION & PARKS DEPARTMENT SPORTS CAMP MEDICAL

### PERMISSION FOR MEDICAL TREATMENT

Student \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date \_\_\_\_\_

In the event of injury, I give my permission for the individual named above to be taken to a hospital; treatment to include evaluation of injury, x-ray and needed medical care. I, the undersigned, understand that I will be responsible for all costs for the medical care of my child.

\_\_\_\_\_  
Parent's Signature

Name & ID# of Health Plan \_\_\_\_\_

#### OTHER PERTINENT MEDICAL INFORMATION:

1. Does your child take daily medication? \_\_\_\_\_ or any as needed medication for a medical problem? \_\_\_\_\_  
Please explain: \_\_\_\_\_  
\_\_\_\_\_
2. Drug, food or insect allergies? \_\_\_\_\_  
Please explain: \_\_\_\_\_  
\_\_\_\_\_
3. Will your child be bringing any medication? \_\_\_\_\_ Name of medication \_\_\_\_\_  
Purpose: \_\_\_\_\_
4. Has your child had a tetanus shot? \_\_\_\_\_ No \_\_\_\_\_ Yes Date \_\_\_\_\_

Parent's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

E-mail \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

\*Please give the name and telephone number of persons you would like notified in the event you cannot be reached and your child becomes ill or injured:

1. \_\_\_\_\_ Phone \_\_\_\_\_

2. \_\_\_\_\_ Phone \_\_\_\_\_

Medical Permission