Little Medical School After School Enrichment Program

PARENT PERMISSION and STUDENT INFORMATION

I give my child permission to participate in the Little Medical School after school program.

_________________________________ ________ _____________

Student's Name Grade Date of Birth

_________________________________ ________________________ _________

Parent/Guardian's Name (Please print) Signature Today's Date

__________________________________ ________________________

Home Address City Zip

__________________ __________________ ________________ _________

Home Phone Work Phone Cell Phone Email Address

EMERGENCY CONTACT INFORMATION

In case of emergency please contact:

________________________ _______________________ ________________

Name Relationship Phone

_______________________________ _____________________

Medical History that may be of importance List any Allergies

________________________ ________________________

Name of Child's Doctor Telephone

*In case of an emergency involving my child, I give permission for the After School Program staff to seek emergency medical treatment for my child and to act as guardian in permitting medical treatment if unable to reach me.

I understand that all emergency and/or medical costs are my responsibility.

___________________ _________________________ ________________

Parent/Guardian Name Signature Date