GENERAL and MEDICAL INFORMATION AND PERMISSION FORM
(Please use a separate form for each child.)

Name:_____ □ Male □ Female
Address:_____
City:_____State:_____Zip:_____
Date of Birth:_____ Age on June 1, 2019:_____ Grade in Fall 2019:_____

Parent/Guardian 1: _____ □ Male □ Female
Email:_____ Cell #:_____ Home#:_____
Employer:_____ Business #:_____

Parent/Guardian 2: _____ □ Male □ Female
Email:_____ Cell #:_____ Home#:_____
Employer:_____ Business #:_____

Child in custody of (check one): □ Both parents □ Mother □ Father □ Other (specify)_____
Child lives with (check one): □ Both parents □ Mother □ Father □ Other (specify)_____
□ In addition to Parent/Guardian names listed above, these person(s) have permission to pick up my child from Summer Academy.
Name:_____ Phone #:_____ Relationship to Student:_____
I understand that my child will not be allowed to leave with any other person without authorization from me.

Health History (*Use back of form if more explanation is necessary*)
□ Asthma □ Bleeding/clotting disorders □ Convulsions □ Ear infections □ Other_____
Allergies: □ Pollen □Penicillin □ Insect stings (type?)_____ □ Food (list)_____
□ Other allergies
(describe)_____
Operations, serious injuries, diseases, or restrictions on physical activity:_____
Current medication and purpose (*all medication sent to Summer Academy must be given to Director and labeled clearly with doctor's instructions*):_____
Learning differences, behavioral conditions, or problems of which staff should be aware (*please note that Special Education Services are NOT available at Summer Academy*):

Parent Authorization/Medical Release: The information provided is correct to the best of my knowledge. The child listed on this form has my permission to engage in all Summer Academy activities, except if noted by me. I (we), the undersigned, authorize Summer Academy staff members to serve as agent(s) for the undersigned to consent to any medical or surgical diagnosis or treatment, anesthetic, X-ray exam, along with treatment and/or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. I (we) understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

PARENT/GUARDIAN SIGNATURE: _____

DATE:_____