



SHOWCASE DEVELOPMENT 2011-2012

MEDICAL ATTENTION FORM

Parent/Guardian Authorization for Medical Attention

I, _____ authorize the following individuals to make all urgent medical and surgical decisions for my child in my absence after two (2) attempts to reach me at _____ have failed.
As the parent or legal guardian, I hereby give consent to ***Kids Unlimited*** to provide all emergency dental or medical care prescribed by a dully licensed Physician (M.D.) Osteopath (D.O.) or Dentist (D.D.S.) for _____
_____. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent.

First Person to contact/Relation to child CELL NUMBER
(not parent or guardian)

Second Person to contact/Relation to child CELL NUMBER
(not parent or guardian)

My child's full name is: _____

Social Security Number is: _____ D.O.B. _____

My Child's past Medical Problems (*write none if applicable*): _____

My child has the following allergies to medicines (*write none if applicable*): _____

My Child is currently on the following medications (*write none if applicable*): _____

Doctor's Name: _____ Phone: _____

Hospital of choice: _____

Parent/Guardian Name: PLEASE PRINT

Parent/Guardian Signature

Date: _____



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INSURANCE POLICY INFORMATION

- YES** The above-named child is covered by health insurance. If yes, provide the following information.
- NO** If no, initial this line stating that you do not have health insurance for your child and are aware that Kids Unlimited does not carry health insurance for your child. _____ Parent/Guardian initials

Policy Holder's (PH) Name _____ PH's Date of Birth _____

Address _____ City _____ Zip _____

Relation to Student _____ Occupation _____

PH's Employer's Name _____

Employer Address _____

Insurance Company Name _____

Insurance Company Address _____

Policy number _____ Group number _____

Medical Emergency Permission

If an injury or other medical condition occurs or arises, I hereby give permission to the **Kids Unlimited Institute of the Arts** representative to provide routine first aid to my child and to seek emergency treatment including X-rays or routine tests. In an emergency situation I give permission for the **Kids Unlimited Institute of the Arts** representative to contact the individuals listed on page 1. I agree to the release of any record necessary for treatment, referral, billing or insurance purposes. I understand that I am financially responsible for medical charges including but not limited to the attending physicians, health care unit and transport to a local medical facility. In the event of an emergency where I cannot be reached to make a decision for my child, I give permission to the physician/hospital selected by the **Kids Unlimited Institute of the Arts** representative and the contact names listed on page 1 to secure and administer treatment for my child, including hospitalization.

Parent/Guardian signature _____ Date _____

Please attach a copy of your insurance card (both sides)



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MEDICATION FORM

Medication Please check the medications your child is allowed to receive from the KU staff. Some medication brands may be in generic form.

- | | |
|---|---|
| Ibuprofen <input type="checkbox"/> | Sore Throat Lozenges (Halls, Ricola) <input type="checkbox"/> |
| Acetaminophen <input type="checkbox"/> | First-Aid type eye wash <input type="checkbox"/> |
| Pepto-Bismol <input type="checkbox"/> | Ace Bandage <input type="checkbox"/> |
| Tums <input type="checkbox"/> | Ice Pack <input type="checkbox"/> |
| Triple Antibiotic Ointment <input type="checkbox"/> | Any necessary bandage <input type="checkbox"/> |
| Other medications not listed _____ | |

Child takes the following medications

1. _____ 3. _____
2. _____ 4. _____

Child has the following medical/food allergies:

1. _____ 3. _____
2. _____ 4. _____

I understand that the above form gives the Kids Unlimited Administrative staff permission to administer the approved medicines to my child. In the event that the child under my care should become sick or injured in such a way that the KU Administration feels unable or unwilling to deal with the situation, I understand that the proper medical personnel will be contacted immediately and also that I (as parent/guardian) will be contacted immediately.

Parent/Guardian Name: PLEASE PRINT

Parent/Guardian Signature

Date: _____