Show Camp and Performance Encounter 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

_______________________________________ Date: __________________________
Parent/Guardian Signature

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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 and 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 ❑
Acetaminophen ❑
Pepto-Bismol ❑
Tums ❑
Triple Antibiotic Ointment ❑
Sore Throat Lozenges (Halls, Ricola) ❑
First-Aid type eye wash ❑
Ace Bandage ❑
Ice Pack ❑
Any necessary bandage ❑
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

____ Date: __________________________
Parent/Guardian Signature