Shaker Heights Recreation Department

Medical Form

Date:

Participant Name: _____ Birthdate: _____ Age: _____

Street Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Business Phone: _____ Email: _____

Medical concerns or special needs (please circle)? **Yes** **No**

If yes, please explain. (Must list all allergies and any special precautions or treatments, including medication indicated for identified conditions)

_____

_____

EMERGENCY CONTACT INFORMATION

Parent/Guardian: _____ Relationship: _____

Street Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Business Phone: _____ Email: _____

Must complete either Part I or Part II below. DO NOT COMPLETE BOTH

PART I: PERMISSION TO TRANSPORT CHILD

This form authorizes the City of Shaker Heights to secure emergency transportation for a child. This form does not authorize or guarantee treatment upon arrival at the designated source of emergency medical or dental treatment, as each emergency facility sets its own treatment procedures.

I give the City of Shaker Heights permission to transport my child, _____

to _____ or to _____ for emergency

medical care, or to the facility nearest available for assistance.

Child's Name

Emergency Medical Care or Hospital/Clinic

Emergency Dentist/Dental Clinic

Parent/Guardian Signature: _____ Date: _____

PART II: REFUSAL TO GRANT PERMISSION

I **DO NOT** give the City of Shaker Heights permission to transport my child, _____ for emergency

Child's Name

medical or dental treatment. I wish the following action to be taken:

_____

_____

Parent/Guardian Signature: _____ Date: _____