

CHILD'S NAME: _____ PHONE: _____ BIRTHDATE: _____ GRADE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

EMAIL: _____

PARENT(S)/GUARDIAN(S) NAME _____ HOME # _____ CELL # _____ WORK# _____

If you can not be reached: Name of person(s) authorized to pick up and/or who can be called in the event of an emergency or illness while at Kid's Hideout.

NAME	PHONE	RELATIONSHIP	NAME	PHONE	RELATIONSHIP
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Names of persons who are authorized to pick your child up from Kid's Hideout.

NAME	PHONE	RELATIONSHIP	NAME	PHONE	RELATIONSHIP
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Name of out-of-state contact in the event of a natural disaster.

NAME	CITY/STATE	PHONE	RELATIONSHIP
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OVER

CONSENT FOR MEDICAL TREATMENT

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT **KID'S HIDEOUT** TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR MY CHILD _____. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

MY CHILD HAS THE FOLLOWING MEDICATION ALLERGIES OR LIMITATIONS:

Physician _____ Phone _____

Address _____ City _____ Zip _____

Hospital Preference _____

Dentist Name _____ Phone _____

Insurance Carrier _____ Plan # _____

PARENT (OR AUTHORIZED REPRESENTATIVE) SIGNATURE

DATE