

# 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, \_\_\_\_\_

Child's Name

to \_\_\_\_\_ or to \_\_\_\_\_ for emergency

Emergency Medical Care or Hospital/Clinic

Emergency Dentist/Dental Clinic

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

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: \_\_\_\_\_