



Emergency Medical Release

This form and the Emergency Medical Release Form **MUST BE COMPLETED** in their entirety in order for your child to be registered for Summer Day Camp.

Name of Child: _____ Birth Date: ____ / ____ / ____
(Last Name) (First Name)

Parent/Guardian Name: _____
(Last Name) (First Name)

Address: _____

City, State, Zip Code: _____

Phone: (____) _____ (____) _____ (____) _____
(Home) (Work) (Cell)

***Please circle which number to call first in an emergency.**

Emergency Contact Persons

Name: _____
(Last Name) (First Name)

Address: _____

City, State, Zip Code: _____

Phone: (____) _____ (____) _____ (____) _____
(Home) (Work) (Cell)

Relationship to Child: _____

Name: _____
(Last Name) (First Name)

Address: _____

City, State, Zip Code: _____

Phone: (____) _____ (____) _____ (____) _____
(Home) (Work) (Cell)

Relationship to Child: _____

Medical History

Identify any medications your child is currently taking (purpose and dosage): _____

Has your child had in the past or currently have any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> diabetes | <input type="checkbox"/> modified diet |
| <input type="checkbox"/> allergies | <input type="checkbox"/> extreme fears | <input type="checkbox"/> recent injury/surgery |
| <input type="checkbox"/> asthma | <input type="checkbox"/> hearing/visually impaired | <input type="checkbox"/> separation anxiety |
| <input type="checkbox"/> autism | <input type="checkbox"/> learning disability | <input type="checkbox"/> other |
| <input type="checkbox"/> cognitive delays | <input type="checkbox"/> limited mobility | |

If yes, please explain: _____

What special accommodations are required for the above conditions: _____

Medical Insurance Company: _____

Physician: _____ **Phone:** (____) _____

Dentist: _____ **Phone:** (____) _____

One purpose of this form is to permit parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Cleveland Metroparks Zoo's care, when parents or guardians cannot be reached. **Part I OR Part II must be filled out prior to your child participating in Summer Day Camp activities.**

PART I, REFUSAL TO CONSENT

I do not give my permission for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish Cleveland Metroparks Zoo authorities to: _____

X **Signature of Parent/Guardian** _____ **Date:** _____

PART II, CONSENT GRANTED

In the event that reasonable attempts to contact me or listed emergency contact persons have been unsuccessful, I hereby give Cleveland Metroparks Zoo my permission to contact my child's doctor/dentist for treatment deemed necessary and, if necessary, to transport my child to any hospital reasonably accessible.

X **Signature of Parent/Guardian** _____ **Date:** _____

