HILLIARD ARTS COUNCIL SUMMER ARTS CAMPS MEDICAL FORM

CHILD'S NAME _____

GUARDIAN'S NAME_____

CAMP(S)
ENROLLED_____

EMERGENCY CONTACT (OTHER THAN ABOVE)
NAME_____DAYTIME PHONE_____
RELATIONSHIP TO CHILD_____

NAME OF PHYSICIAN OR
CLINIC_____PHONE_____
STREET ADDRESS _____
CITY, STATE & ZIP CODE_____

NAME OF DENTIST OR
CLINIC_____PHONE_____
STREET ADDRESS _____
CITY, STATE & ZIP CODE_____

KNOWN ALLERGIES _____

COMPLETE EITHER SECTION 1 OR SECTION 2 – NOT BOTH

SECTION 1 (PERMISSION TO TRANSPORT CHILD)
I give the Hilliard Arts Council Drama Camp permission to transport my child, (Name)_____to (hospital or clinic)_____ for emergency medical care or to (dentist or clinic)_____ for emergency dental treatment, or to the nearest available source of assistance.

Parent's Signature_____Date_____

SECTION 2 (REFUSAL TO GRANT PERMISSION)
I DO NOT give the Hilliard Arts Council Drama Camp permission to transport my child (Name)_____for emergency medical or dental care. In the event of an illness or injury that requires emergency medical or dental treatment, I wish the Hilliard Arts Council to take the following actions:

_____
_____
_____
_____

Parent's Signature_____Date_____