Cloverleaf Community Rec Center / EMF

Name_________________________________ Daytime Phone____________ Birthdate ____________

Mailing Address (include Box #)____

City, Zip____

In the event reasonable attempts to contact me @_____________(home phone) or @ work_______________

Mother's Name____________________________ Place of Work__________________ Phone_________

Father's Name____________________________ Place of Work__________________ Phone__________

If neither parent can be reached, please contact:____

Address;_________________________________ Relationship_________________ Phone___________

I hereby give my consent for: (1) administration of any treatment deemed necessary by:

Dr.________________________________ (preferred physician) Phone____________________ OR

Dr.________________________________ (preferred dentist) Phone____________________ OR

Dr.________________________________ (preferred Specialist) Phone____________________

In the event the designated preferred practitioner is not available, by another licensed physicians or dentists, and (2) the transfer of the child to __________________________ (preferred hospital) Phone____________ Or to any hospital accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained prior to the performance of such surgery.

Mother's Signature____ Date________________

Father's Signature____ Date________________

REFUSAL TO CONSENT: I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I with the school authorities to take no action or to:

Mother's Signature____ Date________________

Father's Signature____ Date________________

Medical problems / non-food allergies / specific food allergies we should be aware of: