

## MEDICAL INFORMATION AND RELEASE

Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Child's history of any of the following conditions. (Be specific as possible)

1. Allergies (bee stings, medications, food, etc.): \_\_\_\_\_

\_\_\_\_\_

2. Physical Handicaps: \_\_\_\_\_

3. Convulsions: \_\_\_\_\_

4. Diabetes: \_\_\_\_\_

5. Heart Trouble: \_\_\_\_\_

List any and all *continuous medication(s)* your child is taking:

1. Name of Medication \_\_\_\_\_

Time of day given: \_\_\_\_\_

Dosage: \_\_\_\_\_

2. Name of Medication \_\_\_\_\_

Time of day given: \_\_\_\_\_

Dosage: \_\_\_\_\_

3. Name of Medication \_\_\_\_\_

Time of day given: \_\_\_\_\_

Dosage: \_\_\_\_\_

Insurance Company, if any \_\_\_\_\_  
(Please attach a copy of the card to the application)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

- I waive and release any claims for damage I may have against the Poarch Creek Indians and Tribal Council, Staff, and Volunteers, for any injuries suffered during participation in registered programs.
- I agree to be responsible for any and all cost of my child's medical care.
- In the event that I cannot be reached, I hereby give the Poarch Creek Indians Staff on duty permission to transport my child to obtain medical attention and/or administer CPR/First Aid until medical attention is obtained.

---

Signature of Parent/Guardian

---

Date