

Name_____

Age_____

CONSENT \ RELEASE FORM

List any medical information that would be necessary for us to know to ensure proper medical treatment.

Allergies_____

Medical Condition_____

Other_____

I hereby grant authority to the Frankfort Park District and the Day Camp Staff to obtain a paramedic to give emergency treatment to my child or obtain ambulance services for my child when it is deemed necessary. I also give permission to the selected paramedic/physician to treat my child as requested by the Frankfort Park District in the event that I cannot be reached. I am aware that any expenses incurred for any of the above services will not be the responsibility of the Frankfort Park district.

Signed_____Date_____
(Parent / Guardian)