**Proehlific Park Authorization to Consent to Health Care for a Minor**

I, ______________________________, of ____________________ County, North Carolina, am the custodial parent of ________________, a minor child, age _______, grade _______. I authorize Proehlific Park, its agents and employees, to provide such first aid and to summon medical assistance to the site of any injury that may occur or to transport or have my child transported to a health care facility for treatment. Specifically, in the event that emergency or immediate medical treatment is necessary, I authorize Proehlific Park to (i) provide basic first aid to my child; (ii) provide for such health care at any hospital or other institution; (iii) employ any physician, dentist, nurse, or other person whose services may be needed for such health care, including the administration of anesthesia, x-ray examinations, performance of operations, and other procedures by physicians, dentists and other medical personnel. I understand that in the event of any emergency, when immediate medical assistance is necessary such emergency treatment may be provided without my consent. I further understand that non-emergency treatment or treatment that is not immediately necessary will be withheld until I can be contacted to provide consent for such treatment. I hereby release and indemnify Proehlific Park, its agents and employees from any and all liability arising from the administration of first aid, the transportation to health care facilities, the rendering of health care by a hospital or health care provider, or the consent for treatment provided by Proehlific Park pursuant to this Authorization to Consent. By signing here, I indicate that I have the understanding and the capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent name herein.

Date: __________________

Signature of Custodial Parent or Legal Guardian:

________________________________________

## EMERGENCY CONTACT AND MEDICAL DATA FORM

Child's Name ______________________________ Grade _______ DOB ____________________

Mother ___________________________________ Driver's License # _____________________

Address ________________________________________________________________________

Home # _____________________ Work # ___________________ Cell # __________________

Father ____________________________________ Driver's License # _____________________

Address ________________________________________________________________________

Home # _____________________ Work # ___________________ Cell # __________________

Child's Doctor ________________________________ Office # _________________________

Child's Dentist ________________________________ Office # _________________________

List any medications your child takes at home daily and dosage.

________________________________________________________________________________

________________________________________________________________________________

Do we need to give your child any prescription medication at Proehlific Park? Yes _____ No_____

If yes, the Authorization for Medication form must be completed and submitted before any prescription medications can be given. NOTE: Any changes in prescription medications to be given must be communicated as soon as possible.

Prescribing Doctor's Name, Phone ______________________________________________

***A copy of the prescription must be attached.***

Medical Insurance Carrier: ___________________________________________________

Policy Holder: ____________________________________________________________

Member ID: _____________________________________ Group #: ___________________________

If neither parent is available whom should we contact?

Name: _____________________________ Relation: _____________ Phone #: _____________________

Name: _____________________________ Relation: _____________ Phone #: _____________________

In case of emergency, the following people have my permission to take my child off campus:

Name, Phone: __________________________________ Name, Phone: ______________________________

Name, Phone: __________________________________ Name, Phone: ______________________________

Please include any medical data (asthma, diabetes, heart murmur, allergies, allergy to bee stings, etc.) plus specific directions to be followed in the event an emergency should occur. (If more space is needed, please us another page)

______________________________________________________________________________

______________________________________________________________________________

Signature: _________________________________