Des Moines Park & Recreation Department
MEDICAL HISTORY & AUTHORIZATION FORM

Name of child: _____
LAST FIRST M.I.

Address: _____ Birthdate: _____

Home Phone: _____ OR _____

MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Address: _____

Health Insurance Provider: _____

Preferred Hospital for Emergency Treatment: _____

Allergies / Medical Concerns: _____

_____

_____

Limitations on activities: _____

_____

_____

Suggestions for handling behavior problems: _____

_____

_____

_____

Authorization for Treatment

I understand that the City, Des Moines Park & Recreation Staff, and all persons related directly or indirectly with the program assume no financial obligations or liability. In the case of accident or illness, I hereby give my permission that my child may be given emergency treatment.

In the event that I cannot be contacted, I further authorize and consent to the administration of any and all medical, dental, and surgical examinations or operations and treatment or all other related care, including the administration of drugs, tests, injuries, anesthesia, and/or blood transfusions to the above named minor person that may be ordered by the physician and/or dentist in attendance at the medical center deemed necessary for emergency treatment. I hereby consent to the release of medical reports to any doctor or agency and consent to the admission of the above named minor person to the hospital.

_____

Printed Name of Parent/Guardian Signature of Parent/Guardian Date