



THE NEW ACADEMY, INC.

PARENTAL PERMISSION AND MEDICAL AUTHORIZATION FORM

Participant Name: _____ **Birth date:** _____

I give permission for my child (named above) to attend the events, field trips, and service projects associated with The New Academy, Inc. of Windermere. I further give permission for my child to be transported to and from events by hired and/or volunteer drivers authorized by The New Academy, Inc.

Medical Release

I hereby authorize The New Academy, Inc., hospitals, licensed medical or dental providers, and their agents and employees to have access to the information contained in this form and to provide all medical or dental care, routine tests, treatment, and necessary transportation advisable for the health and safety of my child. This authorization includes the authority to consent to any x-ray examinations, anesthetic, medical procedure or treatment, and hospital care under the supervision, and upon the advice of or to be rendered by, a physician or surgeon licensed under the Medical Practice Act or dentist licensed under the Dental Practice Act for my child.

Custody Release

I further authorize The New Academy, Inc. to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to said adult.

Activity Release

I further give permission for my child to participate in all supervised activities except as noted:

Signature of Parent or Legal Guardian **Printed name of Parent or Guardian** **Date**

EMERGENCY CONTACT INFORMATION

Parent(s)/Guardian(s)

| | Phone Numbers | Phone Type (Home, Mobile, etc.) |
|----------------------------------|---------------|------------------------------------|
| Name(s) _____ | | |
| Street Address _____ | | |
| City _____ State _____ Zip _____ | | |

 Parent(s)/Guardian(s) Email address(es)

 Email address(es)

 Phone Numbers Phone Type

Other Emergency Contact(s)

(Home, Mobile, etc.)

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| | |
| | |

Name(s) Relationship to Participant

Health Care Information

Participant Name: _____

Physician

Dentist

Name

Name

Phone

Phone

Medical Insurance Company

Dental Insurance Company

Policy/Group Number

Policy/Group Number

Name of Policy Holder

Name of Policy Holder

Please list any allergies to drugs, foods, plants, insects, etc:

Please list any prescription medication to be taken by the participant (including what it is taken for, when it is to be taken, dosage information, and any special procedures):

Please list any non-prescription (over-the-counter) medication you do NOT want dispensed to your child:

Please list any additional information relevant to participating in PF activities (dietary needs; surgeries or serious injuries; chronic or recurring illness; medical conditions such as epilepsy or diabetes; psychiatric counseling or indications, etc.):

Information provided on this form will be kept strictly confidential.