

**CONSENT OF PARENT
MEDICAL CARE AND TREATMENT FORM**

Participants Name _____

Last

First

Date of Birth _____

Parent or Guardian _____

Phone Number: (H) _____ **(W)** _____ **(E)** _____

Home

Work

Emergency

Home

Address _____

Number and Street (P.O. Box)

City

State

Zip

Name and Address of Family Doctor: _____

Health Insurance Company _____

Policy Number _____

If you or your Doctor cannot be contacted, in an emergency notify:

Name	Phone Number	Relationship
Address (Number and Street)	City	State
		Zip

MEDICAL INFORMATION

Drug Allergies _____ **Date of Last Tetanus** _____

Other _____

Verification and Notarization

STATE OF KANSAS, COUNTY OF JACKSON, I _____
(Parent or Guardian) understand that if a serious illness or injury develops, medical and/or hospital care will be given: however the City of Holton is not responsible in case of accidental injury or illness. I further understand that, in case of medical emergency, we will be notified. In the event I cannot be reached, I hereby give permission to a designated member of the City of Holton Parks and Recreation Program, or attending physician to hospitalize, secure proper treatment for, and order injections, anesthesia, or surgery for my child as named on the Health Certificate and do solemnly swear or affirm that the information set forth in the Health Certificate is true and correct to the best of my knowledge and belief.

Parent/Guardian Signature _____

Subscribed and sworn to before me this _____ day of _____ 20 _____

Notary Public _____ My commission expires _____

* Parents: You may have this form notarized at your local bank, City Hall, or any authorized Notary Public.