# *Cedar Springs Waldorf School*

## Summer Camp Medical Release and Health Information

*ONE FORM PER CHILD*

### STUDENT INFORMATION

NAME_____ BIRTH DATE_____

### PARENT (S) NAMES, EMAIL AND PHONE NUMBERS

| Name | Email Address | Phone |
|---|---|---|
| | | ❑Home ❑Cell ❑Work |
| | | ❑Home ❑Cell ❑Work |
| | | ❑Home ❑Cell ❑Work |
| | | ❑Home ❑Cell ❑Work |
| | | ❑Home ❑Cell ❑Work |
| | | ❑Home ❑Cell ❑Work |

### PARENT (S) MAILING ADDRESS

| Street | City | Zip Code |
|---|---|---|
| | | |

### EMERGENCY MEDICAL TREATMENT RELEASE

In the event of an accident or other emergency, when a parent is unavailable, I/we hereby authorize a representative of the school to make such arrangements as are considered necessary for my child to receive medical or hospital care, including necessary transportation. Under such circumstances, I/we further authorize any licensed physician or surgeon to undertake such care and treatment of this child as is considered necessary. The undersigned hereby agree to bear all costs incurred as a result of the foregoing.

_____ _____

*Parent/Guardian Print Name* *Parent/Guardian Signature and Date*

### HOMEOPATHIC FIRST-AID RELEASE

In the event that my child is in need of treatment, I/we give permission to a representative of Cedar Springs Waldorf School to administer homeopathic first-aid medication in addition to basic first-aid.

❑Yes _____ _____

*Parent/Guardian Signature and Date* *Parent/Guardian Signature and Date*

❑ No _____ _____

*Parent/Guardian Signature and Date* *Parent/Guardian Signature and Date*

Note: Cedar Springs Waldorf School is not authorized to administer over-the-counter medications such as aspirin, ibuprofen, cough/allergy medicine, etc.

CONTINUED ON OTHER SIDE

## ALLERGIES OR HEALTH CONDITIONS THAT MAY REQUIRE SPECIAL ATTENTION

(Please describe in detail, any allergy or condition that the school should be aware of and what action is to be taken if your child has a related complication.)

## ROUTINE MEDICATIONS BEING TAKEN AT HOME (Include time and dosage.)

## PHYSICIAN AND INSURANCE INFORMATION

Physician Name_____ Phone #_____

Insurance Company_____ Policy #_____

Insurance Phone Number_____

## PERSONS AUTHORIZED TO PICK UP CHILD/CHILDREN

*EC = Emergency Contact: Person can pick up your child, in an emergency, when the school cannot contact you.*
*AP= Authorized Pick-up: Person can pick up your child from School or Extended Care.*

| NAME | PHONE NUMBER | ER | AP |
|---|---|---|---|
| | | ❑ | ❑ |
| | | ❑ | ❑ |
| | | ❑ | ❑ |

**Parent/Guardian Signature** _____ **Date** _____