

**Hampton Parks and Recreation Department
Parental Consent For Treatment**

1. This form should be completed for any minor – anyone under the age of 18.
 2. This form should be completed and signed by the mother, father, or legal guardian.
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I/We, undersigned, do hereby authorize that certified medical centers/hospitals are given the authority to render necessary medical services to my/our child(ren) which result, directly or indirectly, from his/her participation in the trips, programs, events, activities sponsored by the City of Hampton Parks and Recreation Department; and I/we, the undersigned; also hereby agree to be responsible for such charges made by such medical center/hospital, doctor, etc., in providing such medical services as are referred to above.

A. Child's Name _____

B. Child's Age _____ DOB _____ Birth Cert. # _____

C. Address _____ School Attending _____

D. Your relationship to the child: _____

E. Date of last tetanus booster (lockjaw shot) _____

F. Is your child allergic to any medication?
(Make him/her itch, break out in rash, or have trouble breathing?) No__ Yes _____

G. Who is your child's regular physician? Name: _____ Phone: _____

H. Name and phone number of person who would most likely be able to contact you in case we are unable to reach you. Name: _____ Phone: _____

I. Does your child have a chronic illness? No ____ Yes (illness) _____

J. Does your child take any medication daily at home? No ____ Yes(type) _____

K. This is to certify that I/we have hospitalization insurance with:
Company _____ Policy Number _____

L. Parent/ Guardian Social Security Number _____

M. Do we have permission to give any medical treatment necessary to your child in case we are unable to contact you? Yes _____ No _____

Any Exceptions?List: _____

HOME PHONE

WORK PHONE

PARENT NAME (PLEASE PRINT)

DATE

WITNESS SIGNATURE

PARENT/ GUARDIAN SIGNATURE