

Medical Information

Family Doctor: _____ Phone number: _____

Medical Problems/Allergies/Medications/Special Needs: _____

Allergy to specific foods _____ Allergy to bee stings _____

Health Insurance Co. _____ Policy Holder _____

Policy # _____ Group # _____

Consent For Emergency Treatment and Release of Liability

If emergency treatment is required, I consent to Tredyffrin Township Recreation Program personnel using their judgment in securing medical services most accessible, providing none of the above parent/guardians can be reached. Ambulance cost is my responsibility. Parent/guardian must be at the hospital to assure medical treatment. **Release:** I release Tredyffrin Township from all claims that may result from participation in the above activities. I/my child will abide by the rules and regulations set forth by Tredyffrin Township Parks & Recreation relating to participation in the above activities.

Adult/Parent/Guardian Signature

Date

Tredyffrin Township Tax ID# 23-6000527
(please keep payment receipt)