

CAROLINA FRIENDS SCHOOL PERMISSION and EMERGENCY FORM

Student Name: _____ Date of Birth: _____

Permission & Liability Waiver

My son or daughter, named above, has permission to fully participate in all Carolina Friends School activities, including athletics, during the 2008-2009 school year.

Signature Relationship Date

Signature Relationship Date

I, as parent or legal guardian, do hereby grant Carolina Friends School faculty & designated adults the right to authorize emergency medical treatment for my child named above in the event that I or my designated representative cannot be reached. I agree to hold harmless Carolina Friends School and its agents from liability arising out of an accident situation. The North Carolina Good Samaritan Law will apply.

Signature Relationship Date

Signature Relationship Date

Parent Information

Parent/ _____ Home Phone: _____
Guardian

Email address: _____ Cell Phone: _____

Address: _____
street city state/zip code

Employer/Department: _____ Work Phone: _____

Parent/ _____ Home Phone: _____
Guardian

Email address: _____ Cell Phone: _____

Address: _____
street city state/zip code

Employer/Department: _____ Work Phone: _____

Names of relatives or friends in the event you cannot be reached:

_____ Phone: _____

_____ Phone: _____

Insurance Information (The School requires that your child is covered by health insurance for athletic participation.)

Policy Holder: _____ Employer _____

Insurance Company: _____ Policy # _____

Significant Medical Information

Family Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Orthodontist: _____ Phone: _____

Hospital preference: _____

Chronic Illnesses or Injuries: _____

Allergies (Medications, insect stings, food & other): _____

Asthma Inhaler: _____ Date of last Tetanus Shot: _____

Corrective Lenses? Yes _____ Glasses _____ Contacts: Hard _____ Soft _____

If your child needs Ibuprofen, Tylenol or other medication during the day and you would like CFS personnel to provide any of these medicines, please sign below to authorize them to do so. I give permission to provide to my child:

Ibuprofen _____ Tylenol _____ Benadryl _____

Other _____

Parent signature

Comment on any medical, dental or developmental conditions that would affect your child during a trip or activity:

Physical Limitations: _____

If asthma was checked is an inhaler used during/prior to participation in any activities: yes ___ no ___