

(Please Print) **PERMISSION SLIP & MEDICAL RELEASE**

Child's Name: _____

Birthdate: _____ Present Age: _____ Sex: M F

Address: _____

Zip Code: _____ Phone: _____

Parent / Guardian Name _____

E-mail _____

ADD US TO MAILING LIST FOR OTHER EVENTS FOR KIDS? Yes No

(I) (We), the undersigned, parent(s) of

_____,
Hereby authorize the adult leader(s) in charge as agents for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable. It is understood, and agreed, this authorization will remain in effect indefinitely, unless canceled by the undersigned. I voluntarily allow my child to participate in all of the KidZone activities and take full responsibility for any injury incurred while at KidZone.

Parent/ Guardian Signature _____

Date: _____ Emergency Phone#: _____

Known Drug Allergies: _____

Known Medical Problems: _____

Insurance Company: _____

Policy #: _____