THETFORD RECREATION DEPARTMENT
MEDICAL PERMISSION FORM

PLAYER/CAMPER NAME:_____ DATE OF BIRTH: _____

ADDRESS:_____

PRIMARY CONTACT:	ALTERNATE CONTACT:
Name: _____	Name: _____
Relationship to Camper: _____	Relationship to Camper: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____
E-mail: _____	E-mail: _____

MEDICAL INFORMATION

Any chronic conditions, allergies or medications that could be important in case of sudden illness or injury:

_____

_____

FAMILY PHYSICIAN: _____

TELEPHONE #: _____

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

I hereby give permission for the staff of Town of Thetford to provide simple first aid treatment to my child, _____, when necessary, and in the event of a more serious illness or injury, I give permission for my child to be transported to a hospital or other emergency medical facility to receive emergency medical treatment. I also authorize ambulance/rescue squad attendants to administer such treatment as is medically necessary, and I authorize licensed health practitioners working in the hospital or emergency medical facility to examine and provide emergency medical treatment to me if warranted.

_____ _____

SIGNATURE DATE SIGNED