NORTHPORT-EAST NORTHPORT UFSD
NORTHPORT, NEW YORK 11768

AFTER SCHOOL ACTIVITY MEDICAL INFORMATION

Date _____ Grade _____

Sport/Activity _____

Student's Name _____

DOB _____

Address _____

Home Phone _____

Father _____ Work _____
Cell _____

Mother _____ Work _____
Cell _____

Family Doctor _____ Phone _____

Medical Conditions and Allergies:

_____
_____
_____

Medications:

_____
_____
_____

Other Concerns:

_____
_____
_____

See Next Page

People Authorized to Pick Up Your Child:

Name _____ Phone _____

Name _____ Phone _____

Please Indicate Any Custody Issues:

_____

_____

_____

MEDICAL AUTHORIZATION

I the undersigned parent or guardian of_____, a minor, do hereby authorize _____ or any law enforcement agency to use their judgment in obtaining medical treatment for my child. I give permission to the medical, dental or emergency room staff selected to render any medical, surgical, or dental treatment necessary. It is also understood that any costs incurred for my child for such emergency treatment shall be my sole responsibility. It is also understood that effort shall be made to contact the undersigned prior to rendering treatment to the child, but that none of the treatment will be withheld if the undersigned cannot be reached.

Signature _____

Date _____