PARENTS PERMISSION/MEDICAL INFORMATION FORM

PARENTS:

I_____, having legal custody of _____ grant permission for him/her to participate in Communities in Schools Chatham County Mentoring Program. I understand volunteers approved of and supervised by the program will be citizens from the local community and will be providing companionship, guidance, and recreational activities out of the home for my son/daughter.

MEDICAL:

Since an emergency could arise where staff members or volunteers feel my child would need to go to the hospital or elsewhere for immediate medical attention, I agree for staff members or volunteers to refer the above named person for medical care if needed.

Please indicate the name, address and phone number of preferred physician:

_____

Preferred Hospital: _____ or Closest Hospital: _____

Allergies (food, drugs, etc.)_____

Is your child currently taking medication? Yes_____ No_____ If yes, please include a doctor's note including type of medicine, reasons, times and any contra-indications or side effects of the drug. (Volunteers are not responsible for administering medication to youth.)

Does your child have any medical problems? Yes_____ No_____ If yes, please explain.

_____

Due to my child's health, he/she is restricted from the following activities:

_____

Child's Date of Birth:_____