

To Be Completed by Parent/Legal Guardian

The Columbus Academy Summer Programs Medical Form

Child's Name _____ Date of Birth _____ Age _____

Address _____

Parent/Legal Guardian _____

Address _____

Where can you be contacted during the day? (Home) _____

Other _____ (Work) _____

Family Physician _____ Phone _____

Relative or Friend authorized to act in your behalf if you cannot be reached:

Name	Relationship	Phone
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In case of an emergency, the above child may be treated by a doctor: Yes _____ No _____

List allergies to food, drugs, plants, insects, etc. _____

Special considerations and/or conditions that may require attention:

To the best of my knowledge, the above child is physically fit and in good health. I understand that all standard safety measures will be taken. I do not hold The Columbus Academy Summer Programs or its staff liable for illness or accident.

Parent/Legal Guardian Date