PARENTAL MEDICAL CONSENT

NAME OF STUDENT_____

If it should become necessary, I hereby give my permission to the ACE Academy and to its agents, to secure emergency medical treatment at the nearest medical facility for my minor child while under the care and supervision of agents of the ACE Academy.

1. Does your minor child possess any physical or mental defects requiring special attention, such as epilepsy, hearing loss, diabetes, asthma, etc.; treatment or medication/ or that would make it difficult for them to participate in the ACE Academy Activities? _____Yes____No
If yes, please explain and ensure that medication is with the student each day or they will not be allowed to participate:

2. List all medications child is currently taking:

3. Are there any dietary restrictions?

If so, you will need to provide appropriate snacks and sack lunch that meets their needs.

4. Does your child suffer from motion sickness?

_____
Name of medical insurance Policy No.

Father's/Guardian's name:_____
Home Phone:_____
Address:_____
Place of employment:_____
Work Phone:_____
Cell phone: _____

Mother's/Guardian's Name:_____
Home Phone:_____
Place of employment:_____
Work Phone:_____
Cell phone: _____

IN CASE OF EMERGENCY LOCAL CONTACT:
_____
_____
PHONE NO._____

_____
Parent/Guardian signature Date

SIGN AND RETURN THIS FORM