PHYSICIAN'S MEDICAL RELEASE
PLEASE RETURN BEFORE SEPTEMBER 15TH, 2017

Participant's Name: _____ **Date of Birth:** _____

Participant's Address: _____
_____

Parent's Name and Phone Number: _____

Insurance Co:_____**Policy #:**_____

This section to be completed by Participant's Physician

Diagnosis: _____
_____
_____

Are all immunizations up to date? (**Please attach immunization record**) _____
Date of Most Recent Tetanus Booster: _____
Allergies (food, drug, insect, asthma): _____
Dietary Restrictions: _____

Medication List:

Medication(s) *	Dosage Amount	Reason for Medication(s)	Hour(s) or Time(s) to be Dispensed

Effective Dates: (current year only) From: _____ To: _____

Specific Activities Restricted:_____
_____
Any other areas of concern we should be aware of: _____
_____

I have examined the above child and found the child to be fit to be admitted to the Aaron's Acres program and participate in all activities without risk to the child and to others.

Physician's Name: _____ Date: _____
Address: _____
_____
Phone: _____ Physician's Signature: _____

This section to be completed by Participant's Parents

AUTHORIZATION TO TREAT

Attached to this form is a current Certification/Order from my child's licensed healthcare provider that includes the name of the prescribed medication(s), appropriate dosage, route of administration, the time or special circumstances when the medication must be administered, possible side-effects or reactions and any necessary emergency response. The medication(s) identified in the attached Certification/Order will be carried to Aaron's Acres programs/activities in the appropriately labeled original container and maintained by designated Aaron's Acres staff.

1. That I am primarily responsible for the administration of medication or medical procedures to the aforementioned child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Aaron's Acres and its employees or agents to administer medication or medical procedures to my child pursuant to this authorization.

2. I acknowledge that it may be necessary that medication or medical procedures be administered to my child by individuals, under nurses' supervision, and I hereby specifically consent to such practice.

3. On behalf of my child, and on behalf of both parents of the child, I agree to indemnify and hold harmless Aaron's Acres and its employees and agents against any claims arising out of the administration of medication or procedures consistent with this Authorization.

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____ Date: _____

**Administration of medication/procedures pursuant to this Authorization will be through Aaron's Acres personnel who have received training. It is understood and agreed that Aaron's Acres personnel acting in such capacity are acting within the scope of their employment relationship. No such personnel shall be individually liable to any child, parent or guardian of such child for any civil damages for personal injuries resulting from acts or omissions of Aaron's Acres personnel acting in conformance with approved Aaron's Acres policies governing the administration of medications or medical procedures.