

Consent to Treat

This is to certify that on this date, I _____, as parent or guardian of _____, give my consent to Skatetown and its representative to obtain medical care from any licensed physician, hospital or clinic for the above-mentioned minor, for any injury that could arise from participation in Camp Cool.

Camper's Medical History

Camper's Name: _____ Date: _____

Address: _____ Birth date: _____

Daytime Phone: _____ Evening Phone: _____

If said minor is covered by any insurance company, please complete the following:

Name of insurance company: _____

Address: _____

Policy Number: _____ Group Number: _____

Who to contact in case of an emergency?

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Physician's Name: _____ Physician's Phone: _____

Hospital of choice: _____

Please complete the following

If the answer to any of the following questions is or was yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper. Have you had (or do you presently have) any of the following?

| | Circle One | |
|--|-------------------|----|
| | Yes | No |
| Head injury (concussion, skull fracture) | Yes | No |
| Fainting spells | Yes | No |
| Convulsions/epilepsy | Yes | No |
| Neck or back injury | Yes | No |
| Asthma | Yes | No |
| High blood pressure | Yes | No |
| Kidney problems | Yes | No |
| Hernia | Yes | No |
| Diabetes | Yes | No |
| Heart murmur | Yes | No |
| Allergies | Yes | No |
| Specify: _____ | | |

| Injuries to: | Yes | No |
|--------------|-----|----|
| Shoulder | Yes | No |
| Knee | Yes | No |
| Ankle | Yes | No |
| Fingers | Yes | No |
| Arm | Yes | No |
| Other: _____ | | |

| | | |
|------------------|-----|----|
| Impaired vision | Yes | No |
| Impaired hearing | Yes | No |

Has your son or daughter had a recent tetanus booster? _____ If so, when? _____

Skatetown Ice Arena, 1009 Orlando Avenue, Roseville CA 95661 ♦ 916.783.8550

Is your son or daughter currently taking any medications? _____ What? Why?

Has the doctor placed any restrictions on your son's or daughter's activities? _____

Explain: _____

Signed: _____ Date: _____

(Parent)

Camper's Name: _____