



**After School Art Classes**  
**115 Dixie Drive**  
**Chapel Hill, NC 27514**

**MEDICAL STATEMENT**

School: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Student: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**EMERGENCY CONTACT**

Parent/Guardian Name: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Home Phone (if different from above): \_\_\_\_\_

Mother's Work #: \_\_\_\_\_ Mother's Cell #: \_\_\_\_\_

Father's Work #: \_\_\_\_\_ Father's Cell #: \_\_\_\_\_

**ALTERNATE CONTACT**

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Medical Statement continued for: \_\_\_\_\_

**INSURANCE**

Do you have health or medical insurance? \_\_\_\_\_ In the event of sudden illness or injury to your child, your insurance company may be billed for medical charges incurred during treatment. **Please make a photocopy of your insurance card and attach the copy to this form.** If you do not have a card, please provide the following information:

Name of Insurance Company: \_\_\_\_\_

Policy Number/Group Number: \_\_\_\_\_

Family Doctor or Pediatrician: \_\_\_\_\_

Doctor's Office Phone: \_\_\_\_\_ Location of Office (city): \_\_\_\_\_

**HEALTH HISTORY**

**Please attach a copy of your child's current, completed immunization form.**

Child's Blood Type: \_\_\_\_\_ Date of Last Tetanus Shot: \_\_\_\_\_

Does your child have any medical conditions we should know about? \_\_\_\_\_

For example, any life-threatening allergies to foods, bee stings, or medications? \_\_\_\_\_

Does your child have asthma, migraines, or frequent stomach upsets? \_\_\_\_\_

Dyslexia? \_\_\_\_\_ Diabetes? \_\_\_\_\_ Hives? \_\_\_\_\_

Any Dietary Restrictions? \_\_\_\_\_

Is there any reason we should limit his or her physical activity in any way? \_\_\_\_\_

**Please explain in detail if your answer to any of the above questions is "yes." Tell us what we may do to help your child if any of these happen during After School hours.**

\_\_\_\_\_  
\_\_\_\_\_

Is your child able to swim? \_\_\_\_\_

Medical Statement continued for: \_\_\_\_\_

**MEDICAL AND LIABILITY RELEASE STATEMENT**

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. If I cannot be reached in an emergency, I give my permission to the physician or dentist selected by the After School staff to hospitalize, secure medical treatment and/or order an injection, anesthesia, or surgery for my child as deemed necessary.

I understand that my insurance coverage for my child will be used as the primary coverage in the event medical intervention is needed.

I understand all reasonable safety precautions will be taken at all times by **Cely's House** and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold **Cely's House**, its directors, employees, and volunteer staff liable for damages, losses, or injuries incurred by the subject of this form.

Circle permission:

I **grant / do not grant** permission to **Cely's House** to administer any minor First-Aid (antiseptic spray, cream, bandage) or major emergency care (splints, dressings, CPR) to above named child(ren).

Parent/Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_