3&-&"4& "/% 8"*7&3

* 8F UIF VOEFS@@@@@@ F@E@ @ @ Q@ 6@ S@F@D@ @ @ T@ @ @H@ @ K@ S@F@ J@ B@ @ @
JT PS NBZ UIFSFBGUFS WPMVOUFFS IFS TFSWJDFT QFSNJTTJPO GPS T
QSPHSBN *O DPOTJEF
BMMPXFE UP QBSUJDJQBUF JO TBJE QSPHSBN *
NZ PVS IFJST FYFDVUPST BOE BENJOJTUSBUPST
EJTDIBSHF 1PSUBHF 1BSL %JTUSJDU BOE UIFJS
JOKVSZ PS QSPQFSUZ EBNBHF PG BOZ LJOE TVT
CPEJMZ JOKVSZ PS QSPQFSUZ EBNBHF JT DBVTF
BHFOUT PS PUIFSXJTF

* 8F DPWFOBOU BOE BHSFF UP JOEFNOJGZ BOE
GSPN BMM MJBCJMJUZ MPTT BOE FYQFOTF JOD
BSJTJOH GSPN UIF QBSUJDJQBUJPO PG TBJE TUV

* 8F GVSUIFS BHSFF UIBU TBJE TUVEFOU XJMM
BOE GVSUIFS BHSFF UP QSPWJEF UIF SFRVFTUFE
SFWFSTF TJEF PG UIJT GPSN

"11&"3"/$& 3&-&"4&

5IF VOEFSTJHOFE UPHFUIFS XJUI NZ DIJME XBT
BOE VTF NZ OBNF MJLFOFTT NPWFNFOU BOE
EJTUSJCVUJPO FYIJCJUJPO BEWFSUJTJOH QVC
%JTUSJDU * BOE PO CFIBMG PG NZ DIJME X
DPQZSJHIUT BOE UIF QIPUPHSBQIT BOE PS BVEJ

____ agree ____ disagree

3&(*453"5*0/ */'03."5*0/

/BNF PG 1BSUJDJQBOU @@@@@@@@@@@@@@@@@@@@@@@@@@@ #JSUI EBUF @@@@@@@@

"EESFTT @@@

$JUZ 4UBUF ;JQ @@@

1IPOF @@@@@@@@@@@@@)PNF @@@@@@@@@@@@@@@@@@@@@@@@@@@@ #VTJOFTT

&NBJM @@@

* 8F ____ IBWF SFBE
UIJT $POTFOU BOE XJUI GVMM VOEFSTUBOEJOH PG UIF UFSNT BOE PG NZ PVS G
PO UIF ____ EBZ PG ____ ____

@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@ @@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@
8JUOFTT 1BSFOU (VBSEJBO 4JHOBUVSF

____
1BSFOU (VBSEJBO 1SJOUFE /BNF

____
%BUF

MEDICAL INFORMATION AND CONSENT TO TREATMENT

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Phone #: _____ (Home) _____ (Cell) _____ (Business)

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Phone #: _____ (Home) _____ (Cell) _____ (Business)

MEDICAL HISTORY

List any history of medical problems or special circumstances we should be aware of:

_____

_____

_____

AUTHORIZATION, SIGNATURE AND CONSENT TO TREAT

In the event of injury or illness, I authorize on behalf of myself (or my child/ward, having not attained the age of 18), Portage Park District to obtain first aid and/or medical treatment at the nearest and most adequate facility of Portage Park Districts' choice. This medical treatment authorization form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances for myself (or my child/ward) (if the participant is under 18 years of age, the parent/guardian must sign).

Signature: _____