COMPLETE BOTH SIDES

## ACTIVITY PERMISSION FORM

Student Name ______________________________________________ Male ______ Female ______

E-mail ______________________________________________________________________

Grade ________________________________ Birth date ___________________________________

Parent's Names ______________________________________________________________

Address ______________________________________________ City _____________ Zip _________

Home Phone _____________ Parent's Daytime Phone ____________ Parent's Cell Phone _________

Health Insurance Company _____________________________________________________

Policy # ____________________________________________________________________

In case parents cannot be reached:
Emergency Contact Name & Relationship ________________________________________________

Emergency Contact Phone Number ___________________________________________________

I Hereby give permission for ________________________________________________________
Students name

To attend __________________________________________________________________
Activity name

and authorize the physician selected by the South Haven personnel entrusted with the care of my child to order X-rays, routine tests, and treatment for the health of my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the South haven personnel entrusted with the care of my child to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child named above.

_____________________________________________ ______________________________
SIGNATURE OF PARENT.LEGAL GUARDIAN DATE

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# Youth Medication Check-out Form

Youth's Name: ______________________________________________

Parent's Names: ______________________________________________

My child has the following allergies:______________________________________

______________________________________________________________

**Daily Medications**:

| Type: | Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|---|
| Quantity (per dose):<br><br>Times to be taken:<br>A.M._____ NOON______ P.M. ______ | | | | | | | |
| Check indicates distribution completed. | | | | | | | |

| Type: | Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|---|
| Quantity (per dose):<br><br>Times to be taken:<br>A.M._____ NOON______ P.M. ______ | | | | | | | |
| Check indicates distribution completed. | | | | | | | |

| Type: | Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|---|
| Quantity (per dose):<br><br>Times to be taken:<br>A.M._____ NOON______ P.M. ______ | | | | | | | |
| Check indicates distribution completed. | | | | | | | |

**As Needed Medications**:

| Type: | Type: | Type: |
|---|---|---|
| Quantity: | Quantity: | Quantity: |

**Parent's Signature:** ______________________________