

EMERGENCY AUTHORIZATION

I hereby give my permission to authorize emergency medical treatment in the event of injury/illness to my daughter. The health care provider is authorized to perform emergency medical services upon consent of the adult in charge from the _____ Grand Assembly, International Order of the Rainbow for Girls.

MEDICAL INFORMATION

Check all conditions which apply to your daughter. Give specific cause of allergies and any special medical information that applies.

ALLERGIES:

Drugs _____
Food _____
Hay Fever _____
Insect Stings _____
Poison Ivy _____

CHRONIC/RECURRING ILLNESSES:

Asthma _____
Diabetes _____
Ear Infections _____
Epilepsy _____
Heart _____

DATE OF LAST:

Tetanus toxoid immunization _____
Health Exam _____

List any other current/recurring illness(es):

PHYSICAL LIMITATIONS:

MEDICATION AUTHORIZATION

No Rainbow Girl should keep medication in her possession. All medications must be turned in to the adults in charge.

The adults in charge have my permission to dispense:

1. My daughter's medication (circle one) Yes No
If yes, name of medication, dosage and schedule: _____

2. Non-aspirin substitute (such as Tylenol) to my daughter (circle one) Yes No
If yes, amount: _____

* * * * *

I certify that all of the above information is correct.

Signature of Parent/Guardian

Date

(Complete both pages of this form)