PERMISSION SLIP FOR PARK COUNTY LIBRARY SYSTEM PROGRAM

Name of Participant: *(Please Print)* ____

Name of Parent/Guardian: *(Please Print)* ____

Address: ____ *Phone:*_______________________________________

I, the parent or guardian of the above named minor, give my permission for my child to participate in the program described as follows:

Date:______________________________ Start Time: ________________________ End Time: ________________________

Location and activities:

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Medical Information and Release

The following special health problems concerning my child should be noted – if none, please check “none”;

□ Heart condition □ Allergy (specify below whether food, bee sting, etc.) □ Asthma

□ Hemophilia □ Diabetes □ Other □ None

Describe condition noted above with particularity, including any medications or other instructions:

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In the event of a medical emergency, I hereby authorize the librarian/chaperone attending to my child to secure medical attention or hospitalization for my child.

Child’s physician: __________________________________ Physician’s phone number_____________________________

Parent/Guardian contact numbers: (home): _______________ (work): _______________ (cellular):________________

Alternative emergency contact: ______________________________ Relationship to child: _________________________

I understand the Park County Library System does not provide medical insurance for my child for purposes of this activity, and I am solely responsible for providing such insurance and for payment of any medical treatment expenses for my child that are not covered by insurance.

I have read the information, verifying its accuracy, and agree to the statements made above:

____ _________________________________

Parent/Guardian Signature Date