



# Geneva Safety Town

## Medical Information & Use of Photography Consent Form

Name of child \_\_\_\_\_ Date of birth \_\_\_\_\_

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Name of child \_\_\_\_\_ Date of birth \_\_\_\_\_

### **Parent/Legal Guardian Information:**

Parent name \_\_\_\_\_

Contact number: \_\_\_\_\_

Parent name \_\_\_\_\_

Contact number: \_\_\_\_\_

### **List two other contacts in case of emergency:**

Name \_\_\_\_\_ Contact number: \_\_\_\_\_

Name \_\_\_\_\_ Contact number: \_\_\_\_\_

### **Authorized person(s) to pick up/drop off my child(ren):**

Name \_\_\_\_\_ Contact number: \_\_\_\_\_

Name \_\_\_\_\_ Contact number: \_\_\_\_\_

Name \_\_\_\_\_ Contact number: \_\_\_\_\_

Name \_\_\_\_\_ Contact number: \_\_\_\_\_

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## Medical information

Family Physician: \_\_\_\_\_ Contact number: \_\_\_\_\_

Family Dentist : \_\_\_\_\_ Contact number: \_\_\_\_\_

List any allergies (bee stings, medication, food, etc.- if so, please list along with any medication used): \_\_\_\_\_  
\_\_\_\_\_

Does the child suffer from: \_\_\_ asthma \_\_\_ diabetes \_\_\_ epilepsy?  
If so, indicate the type of medication that is used: \_\_\_\_\_

Does the child wear contacts or corrective lenses? \_\_\_\_\_

Medications regularly taken: \_\_\_\_\_

Permission to administer child's medication during program (if necessary): YES \_\_\_\_\_ NO \_\_\_\_\_

Other important information to be known by staff:

As a parent and/or guardian, I do herewith authorize the City of Geneva to provide transportation to the nearest hospital for my minor child in the event of a medical emergency while they are participating in a City of Geneva Safety Town Program.

I grant permission for the City of Geneva to take and use photographs for the purpose of Geneva Safety Town.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent/Legal Guardian)