

DISCLAIMER

IN THE EVENT THAT MY CHILD SHOULD HAVE A SUDDEN ILLNESS OR ACCIDENT WHILE AT THE SUBURBAN NORTH FAMILY YMCA SCHOOL AGE CHILD CARE PROGRAM, I UNDERSTAND THAT THE STAFF WILL ATTEMPT TO REACH ME FOR INSTRUCTIONS. IF I CANNOT BE REACHED IMMEDIATELY OR IF THE SITUATION IS VIEWED AS CRITICAL BY THE YMCA STAFF, I REQUEST THAT ONE OF THE FOLLOWING PHYSICIANS BE CALLED, BUT IF EMERGENCY TREATMENT IS NEEDED, I AUTHORIZE THE YMCA STAFF TO REQUEST ASSISTANCE FROM THE PARAMEDICS OR EMERGENCY ROOM STAFF. IT IS UNDERSTOOD THAT THE EFFORT WILL BE MADE TO CONTACT THE UNDERSIGNED BEFORE TREATMENT IS GIVEN, BUT THAT TREATMENT WILL NOT BE WITHHELD IF I CANNOT BE REACHED. IT IS ALSO UNDERSTOOD THAT I WILL BE RESPONSIBLE FOR ALL COSTS INVOLVED IN TREATMENT OF THIS MINOR CHILD.

PARENT/GUARDIAN SIGNATURE

DATE

PHYSICIAN NAME & ADDRESS

PHONE

PHYSICIAN NAME & ADDRESS

PHONE

DENTIST NAME & ADDRESS

PHONE

PREFERRED HOSPITAL & ADDRESS

PHONE

HEALTH INSURANCE CARRIER _____

POLICY NUMBER _____