CITY OF DOWNEY
COLUMBIA MEMORIAL SPACE CENTER

STATEMENT OF HEALTH & CONSENT

Participant Name_____Age_____Date of Birth_____
Grade Participant Entering:_____Phone_____
Address_____City_____Zip_____
Father's Name_____Wk.Phone_____Cell Phone_____
Mother's Name_____Wk.Phone_____Cell Phone_____
Alternate Emergency Contact_____Wk._____Cell_____
Parent / Guardian Email:_____
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HEALTH INFORMATION

A. PARTICIPANT MEDICATION
The person of the program must be notified if medicine is brought to the program. At any time if something should happen to the participant that would alter this health history, prior to or during the program, please contact the staff immediately.

Does the participant take any medication at the present time?
Yes____ No____

If so, what?_____
Dosage_____
Time Schedule_____

I have read the Participant Medication Guidelines located on the back of this form.

Signature_____Date_____

B. ALLERGIES
If the participant has any allergic reaction to any of the following, Please list:

Drugs_____
Other_____

C. IMMUNIZATIONS
Tetanus Date_____
Polio Booster Date_____

Has the participant been exposed to any communicable diseases during the three weeks prior to the program?
Yes____ No____

If yes, please explain_____
_____

Are there any other factors or conditions the staff should be aware of? Please list, if any_____
_____

Please list ALL of the individuals who are allowed to pick up your child from this program including parent/s or guardian/s.
_____
_____
_____
_____

SECTION #1 - CONSENT

I herby give permission for my child to participate in the event and release the City of Downey, Columbia Memorial Space Center and it's employees from all responsibilities resulting from this program. I understand that the event is sponsored by the Columbia Memorial Space Center, supervised by qualified personnel, and it covers all activities including those away from the program which involves transportation.

Signature_____Date_____

MEDICAL RELEASE

Please read and sign EITHER Section #2 or Section #3.

SECTION #2
I herby designate the Columbia Memorial Space Center, or his nominee, as my agent with full authority to authorize emergency medical or surgical treatment, health services and care for said minor by any physician or surgeon or any licensed hospital whenever such treatment or care is required for any condition which endangers the life and limb of said minor.

Signature_____Date_____

SECTION #3
I do not consent to medical treatment.

Signature_____Date_____

SECTION #4 - PHOTO RELEASE
Photos may be taken of your child and be used for publication of publicity by the City of Downey.

Should you have any questions regarding this policy, please call the Center Coordinator at 562.231.1200.