little medical school®

Little Medical School of Rochester Registration Form

To be completed and placed on file prior to registration

Date of Service Requested: _____

Child's Information:

Name of Child: _____ Age: _____

Please name any and all allergies/medical conditions (we need to be aware of)

_____

Please give any information concerning your child(ren) which will be helpful in his/her experience in a group setting (such as eating habits, special fears, likes and/or dislikes).

_____

Parent/Guardian Information:

Parent/Guardian's Name: _____

Cell Phone: _____ Alternate Phone: _____

Other Guardian's Name: _____

Cell Phone: _____ Alternate Phone: _____

In the event of an emergency or non-emergency situation requiring medical treatment,

I, _____ *hereby grant permission for any and all medical attention to be administered to my child(ren), in the accidental injury or illness until I can be contacted.*

Children must stay within sight of instructor(s) at all times. It is imperative that the children behave and obey instructors. Potential safety hazards will be discussed. Children whom create or influence problems will be asked to be picked up early by their guardian, in which you will not receive a refund. Please do not bring any electronic games, toys or other distractions.

I am the parent or guardian of the named child(ren) who is/are participating in Little Medical School classes. I hereby give my approval to the participation in any and all of the activities of this program.

I give permission for photographs taken at Little Medical School to be used for publicity.

_____

(Please Print Guardian Name)

_____

(Signature of Guardian) (Date)