

THE CHILDREN'S  
**MUSEUM**  
at SARATOGA  
**Summer Camp**  
**Medical Information Form**

This form must be filled out completely prior to leaving your child at The Children's Museum at Saratoga.

**Child Information**

Child's Name	Date of Birth	Gender	
Parent's/Guardian's Name	Parent's/Guardian's Name		
Home Phone	Cell Phone	Home Phone	Cell Phone
Address	Address		
City, State, Zip code	City, State, Zip code		

Is your child presently being treated for an injury or sickness, or taking any form of medication for any reason?  
Yes\_\_ No\_\_ If yes, explain: \_\_\_\_\_

Is your child allergic to any type of food or medication?  
Yes\_\_ No\_\_ If yes, explain: \_\_\_\_\_

**Emergency Contacts**

Primary Emergency Contact	Secondary Emergency Contact		
Home Phone	Cell Phone	Home Phone	Cell Phone
Address	Address		
City, State, Zip code	City, State, Zip code		

**Medical Information**

Hospital/ Clinic preference	
Physician's Name	Phone Number
Insurance Company	Policy Number
Allergies/Special Health Considerations	



**Authorized Pick-Up**

Name	Relationship to Child	Phone Number

**RELEASE OF LIABILITY**

I understand that the risk of injury is inherent in any activity physical in nature. I, hereby consent to my child's presence at The Children's Museum at Saratoga for Summer Camp. I do, hereby, for myself, my child, heirs and executors forever waive and release The Children's Museum at Saratoga, its employees and agents from any and all claims, actions, demands, rights and damages of any nature whatsoever, that I or my child may have at any time against The Children's Museum at Saratoga, its directors, officers, employees and agents.

It is hereby understood that The Children's Museum at Saratoga is not responsible in any way for damage of loss of any personal property which the child or parent/guardian brings onto the premises of The Children's Museum at Saratoga.

\_\_\_\_\_  
Parent's/Guardian's signature

\_\_\_\_\_  
Date

**AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR**

I, the undersigned, parent/guardian of the above names person, a minor, do hereby authorize The Children's Museum at Saratoga Management as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical practice Act on the medical staff of any accredited hospital, where such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

I further agree to be responsible for all costs associated with any treatment provided in compliance or attempted compliance in good faith with this consent.

\_\_\_\_\_  
Parent's/Guardian's signature

\_\_\_\_\_  
Date

**PHOTO AUTHORIZATION AND RELEASE**

I hereby grant to the Children's Museum at Saratoga the right to photograph my child and use the photo, film and or other digital reproduction of him/her for publication purposes, whether electronic, print, and digital or internet publishing. I certify that I am a custodial parent and have the aforementioned rights to assign.

\_\_\_\_\_  
Parent's/ Guardian's Signature

\_\_\_\_\_  
Date