Medical Authorization Form

Child's Name: _____ Date of Birth: _____
Last First

List any existing medical conditions, medications and/or special attention your child may require?

_____

_____

_____

Medically Diagnosed Allergies: _____

_____

_____

All Medically Diagnosed Allergies MUST be accompanied by a Doctor's statement and FARE plan.

Parental Preference Allergies:_____

_____

_____

If I cannot be reached to make arrangements for emergency medical attention, **I authorize KIDS Rainbow Academy to take my child to:**

☐ ☐ ☐

Cook Children's	**John Peter Smith Hospital**	**Kindred Hospital**
801 7th Ave	1500 S Main St	815 8th Ave
Fort Worth, TX 76104	Fort Worth, TX 76104	Fort Worth, TX 76104
(682) 885 - 4000	(817) 702 - 3431	(817) 332 - 4812

☐ Other. _____

Parent Signature:_____Date:_____