



KIDS YOGA - EMERGENCY MEDICAL AUTHORIZATION FORM

CHILD INFORMATION

Full Name: _____
Date of Birth: _____ Age: _____
Home Address: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1: _____
Phone: (Home) _____ (Cell) _____
Email: _____
Parent/Guardian #2: _____
Phone: (Home) _____ (Cell) _____
Email: _____

EMERGENCY CONTACTS (If parents/guardians cannot be reached)

Name: _____
Relationship to Child: _____
Phone: _____
Name: _____
Relationship to Child: _____
Phone: _____

MEDICAL INFORMATION

Primary Physician: _____
Phone: _____
Medical Insurance Carrier: _____
Policy/Group #: _____
Allergies or Medical Conditions: _____



Current Medications: _____

Physical Limitations or Special Needs: _____

EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned parent/legal guardian of the child named above, hereby authorize the staff of Kids Yoga to consent to emergency medical treatment for my child in the event that I cannot be contacted, or if immediate attention is required in the judgment of the staff.

I understand that every effort will be made to contact me or my emergency contacts before and during any medical treatment. I understand that all medical expenses incurred will be the responsibility of the child's family or family insurance.

This authorization is valid from the date signed until revoked in writing.

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Name (Printed): _____

Please notify the instructor immediately of any changes to the information provided on this form.