Rebellion Gallery

MEDICAL/HEALTH INFORMATION

Artist's Last Name	**Artist's First Name**	**Initial**
Date of Birth	**Gender**	**Age as of Beginning of Session**
Health Card #	**Doctor's Name**	**Doctor's Phone #**

Does your child have any medical conditions we should know about, such as allergies, phobias, or other relevant conditions?

Does your child going through any personal challenges resulting in behavioral issues that we should know about such as a recent death; any conditions that will require additional support from our Programming Consultants (easily frustrated, issues with conflict resolution)?

Does your child carry an epi-pen? YES NO

Is our child receiving some sort of on-going medical or psychiatric therapy at present?

Describe your child's comfort and abilities as a swimmer? Does he or she have any water-related concerns we should know about?

OTHER INFORMATION: Is there anything else we should know that may circumscribe or limit your child's involvement in our program? Please provide any other information that would help us keep your child safe and happy with us.

I, _____, authorize the physician in the Emergency Care Unit of the hospital chosen by Rebellion Gallery Programming Consultants to secure proper medical treatment for the child named and described on this form. I understand that every effort will be made to contact me prior to any treatment deemed necessary. By signing this form, I am confirmed permission as described, as well as the accuracy of the contact information provided to the Programming Consultants at Rebellion Gallery.

SIGNATURE OF PARENT_____ DATE _____

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