WSTC KidZone Emergency Medical Form & Waiver

Child's Name, Age, Birthdate: Annie Levine; 9 years old; April 9, 2016

Parent 1 Name Doug Levine — Parent 1 Cell # (617) 271-8333

Parent 2 (if applicable) Leah Levine — Parent 2 Cell # (781) 608-3325

Email (1) douglevine@gmail.com — Email (2) leahlevine1@gmail.com

Address 9 Gray Birch Lane, Wayland, MA 01778

Names of 3 people who may be called or to whom your child may be released in case you cannot be reached:

Name Barbara Levine (Grandma) — Cell # (781) 254-9642

Name Heidi Seaborg — Cell # (413) 230-9431

Name Kate Guidice — Cell # (207) 837-0131

Child's Doctor Dr. Joshua Gundersheimer — Phone (781) 899-4456

Child's Dentist Dr. Liliana Gomez-Infante — Phone (617) 645-4925

Describe any accident, operations or serious illness in the past year:

_____

_____

Describe any known allergies:

_____

_____

Describe other medical concerns which may require attention:

_____

_____

Has your child ever been bitten or stung by an insect that caused an unusual reaction?

YES ( ) NO ( ). If YES, what type of insect? _____
Describe the reaction (breathing difficulty, swelling/size, hives, etc.):

_____

_____

Ambulance will transport children in an emergency to the following hospitals: Emerson, Leonard Morse, Framingham Union and Newton-Wellesley. In an extreme emergency, the nearest hospital will be chosen by the EMTs. From these hospitals listed above, please indicate your preference:_____

I realize that participation in the aforesaid program involves some risk of personal injury; therefore I hereby release and covenant to hold harmless the Wayland Swim and Tennis Club and their respective agents, contractors and employees of and from any and all actions, claims and damages for personal injuries and disabilities that I or my child may have sustained and may have incurred as a result of participation in your program.

Signature_____Date_____