

Dietary modifications _____

Current medications (list all with copy of instructions)

Other diseases or details: _____

Name and address of family physician _____

_____ Phone No. _____

May adults in charge administer:	Aspirin.....	Yes _____	No _____
	Tylenol.....	Yes _____	No _____
	Advil.....	Yes _____	No _____
	Dramamine.....	Yes _____	No _____

Insurance Coverage:

Insurance Name _____

Phone No.() _____ Policy No. _____

I hereby give permission to the Physician selected by the adult in charge of Crew 370's activity to order X-rays, routine tests, and treatment for the health of my child, and in the event that I can not be reached in an emergency, I hereby give permission to the physician selected by the adult in charge to hospitalize, secure proper treatment for, and to order injections and or anesthesia and/or surgery for my child.

(Name)

Social Security Number of Primary Insured _____ - _____ - _____

Print Name of Insured _____

TO BE SIGNED IN PRESENCE OF NOTARY

Date _____

Signature of Parent or Guardian

STATE OF FLORIDA
COUNTY OF BREVARD

The foregoing instrument was acknowledge before me this _____ day of _____, 20_____

by _____, who is personally known to me or who has produced
_____ as identification and who did not take an oath.

Signature of Notary

Name of Notary printed or stamped