

# 2010 Space Voyage Academy Medical Form

## Consent For Medical Treatment For Minor Aged Visitors

(Parents, please complete this form for your child along with the Medical Waiver.  
Please mail this to: SVA 1504 South Johnson Court, Lakewood, CO 80232)

**In order to provide your child medical care in the event of illness or injury, you are requested to complete this form.**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Academy Week(s) attending; (Circle) 1 2 3 4 5 6 7 8 9

Father's Name: \_\_\_\_\_

Telephone Numbers: Home= \_\_\_\_\_ Work= \_\_\_\_\_ Cell= \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Telephone Numbers: Home= \_\_\_\_\_ Work= \_\_\_\_\_ Cell= \_\_\_\_\_

Other Contact; \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Where is this child staying at the time of the camp? With Parents \_\_\_\_\_ Other \_\_\_\_\_ (please specify)

### Insurance information:

Carrier: \_\_\_\_\_ Plan #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

### Medical History:

1. Date of last tetanus booster: \_\_\_\_\_

2. Does your child have any allergies to medications, foods or insect stings? NO YES

If yes, please explain: \_\_\_\_\_

3. Is your child under the care of a health care provider for a medical problem? NO YES

If yes, please explain: \_\_\_\_\_

4. Is your child taking medication prescribed by a health care provider? NO YES

If yes, please explain: \_\_\_\_\_

5. Other Information we should be aware of: \_\_\_\_\_

**Parental Permission:** I give permission for such first aid procedures as may be deemed necessary for my son/daughter by Space Voyage Staff and any other medical facility. I understand that any health care facility will make every reasonable attempt to contact me first, time and conditions permitting. I agree to be responsible for all charges incurred.

Signed: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_