



Rural Municipality of
WEST RIVER

Emergency Medical Form

Please Print

Date: _____
(to cover full term at West River Child Care Centre)

Child's Name: _____
(One form per child)

In the event of serious injury to my child, and the supervisor/staff of West River After School Program are unable to reach me or my emergency contact, I hereby give permission for The Rural Municipality of West River to act on my behalf in obtaining and/or authorizing emergency medical treatment for my child. I understand that any treatment would be on the advice of a qualified medical professional.

Parent 1/Guardian _____
Signature Printed Name Date

Parent 2/Guardian _____
Signature Printed Name Date

Medical Information Please list any physical restrictions and particulars of child's health that should be noted

Allergies: _____

Epipen Required: Yes ☐ No ☐

Drug Allergies: _____

Health Card Number: _____

Family Doctor: _____ Phone: _____

Afton Imagination After School Program

License #L4655

TO BE RETURNED WITH APPLICATION