

Town of Cochrane  
Recreation, Culture & the Arts

MEDICAL INFORMATION

Child's Name \_\_\_\_\_ Phone \_\_\_\_\_

AHC# \_\_\_\_\_

EMERGENCY CONTACT:

\_\_\_\_\_  
(Name) \_\_\_\_\_ (Relationship)

\_\_\_\_\_  
(Phone/Cell Number) \_\_\_\_\_ (Email)

Please list all conditions, symptoms and all medical information that may affect your child's participation: (i.e. allergies, reactions, medications, behaviors, etc)

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I, \_\_\_\_\_ hereby authorize the staff of the  
Town of Cochrane Recreation to supervise administration of medications by my child  
\_\_\_\_\_ as per the information and instructions given above.

I acknowledge that the Town of Cochrane is not responsible for administering medication to my child and I assume full responsibility for any medications taken by my child during this program.

\_\_\_\_\_  
(Parent/Guardian Signature) \_\_\_\_\_ (Date)