



KALEO ACADEMY PERMISSION FORM

I, _____, am the parent or legal guardian of _____,
Name of parent or guardian Name of minor

I give permission for my child to participate in all the activities of the Kaleo Academy, unless otherwise stated below, and I hereby authorize Kaleo Academy and their officers, agents, servants, or employees who supervise these activities to consent to medical care for my child. The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and licensed surgeon. It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the supervisor and his/her authorized designee, in the exercise his/her best judgment on what is advisable for my child's care, upon advice of such physician, dentist, and surgeon.

I approve of my child's Mentor selection, who has also been approved by a member of our pastoral staff.

I also give permission for Kaleo Academy to use any photos or video images of my child for promotional purposes only.

Signature of parent or legal guardian Date

Emergency Contact Person: _____ Relationship to Minor: _____

Phone Number: _____

KALEO ACADEMY MEDICAL FORM

HEALTH CARE INFORMATION

Name of family physician _____ Phone _____

Other doctors _____ Phone _____

Is this applicant covered by medical/hospital insurance? YES NO

Insurance carrier _____ Policy Number _____ Group Number _____

Responsible Party _____ Relationship _____ SSN _____

MEDICAL HISTORY

Please indicate any Medical History we may need to be aware of:

Current Medications, Instructions or Allergies:

List any Dietary or Activity restrictions:

Signature of parent or legal guardian Date