

NASHOBA BROOKS SCHOOL OF CONCORD  
**SUMMER CENTER**  
200 Strawberry Hill Road  
Concord, MA 01742

STATEMENT OF PERMISSION AND RELEASE  
&  
CONSENT AND PERMISSION FOR EMERGENCY MEDICAL AND  
SURGICAL TREATMENT

In consideration of our/my child \_\_\_\_\_ receiving permission from  
\_\_\_\_\_ to take part in all Summer Center activities,  
(parents/guardians name)

the receipt of such permission is hereby acknowledged, each of the undersigned hereby releases Nashoba Brooks School of Concord, its agents, officers, servants, employees and volunteers of and from any and all liability, claims, demands, actions, and causes of action whatsoever, arising out of or related to any loss, damage, or injury that may be sustained by said child, or any property of any and each of the undersigned while taking part in Summer Center activities. This release shall be binding upon the heirs, executors, administrators and assigns of the undersigned. The undersigned has read the foregoing release, understands it and signs it voluntarily.

\_\_\_\_\_ residing at \_\_\_\_\_  
(parents/guardians) (street address)  
\_\_\_\_\_ parents of \_\_\_\_\_  
(town) (state) (zip) (students name)

a student at Nashoba Brooks School Summer Center of Concord, Massachusetts, wishing to provide for emergency medical and surgical care for the child, hereby grant permission to medical personnel, physicians and surgeons, first aid stations, medical clinics, and hospitals to provide diagnostic procedures, hospital care, and such medical, clinical or x-ray treatment as any attending physicians, medical, clinical or hospital personnel deem is necessary in their judgment in the event that I and my emergency contact or physician cannot be reached in an emergency. I further consent to the administration of anesthesia and to the use of such anesthesia as may be deemed desirable. This form has been fully explained and signature of it certifies an understanding of its contents.

\_\_\_\_\_  
\_\_\_\_\_  
(parents/guardians)

**NASHOBA BROOKS SCHOOL OF CONCORD**

**EMERGENCY INFORMATION SHEET**  
(This form is required for Summer Center attendance)

CHILD'S NAME \_\_\_\_\_ GRADE(in Fall) \_\_\_\_\_

HOME PHONE \_\_\_\_\_ HOME ADDRESS \_\_\_\_\_  
\_\_\_\_\_

PARENTS' NAMES \_\_\_\_\_

Dr./Mr./Mrs./Ms. DAYTIME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

Dr./Mr./Mrs./Ms. DAYTIME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

ANY OTHER PHONE NUMBER(where you can often be reached) \_\_\_\_\_

EMERGENCY CONTACT (to be called if parents cannot be reached) NAME \_\_\_\_\_  
PHONE \_\_\_\_\_

**NAMES AND PHONE NUMBERS FOR:**

PRIMARY PHYSICIAN \_\_\_\_\_

OTHER PHYSICIAN \_\_\_\_\_

DENTIST \_\_\_\_\_

ORTHODONTIST \_\_\_\_\_

**ALLERGIES OR CONDITIONS WHICH WOULD REQUIRE SPECIAL AND/OR IMMEDIATE TREATMENT**

Medication or Drug Allergy Yes/No Drug \_\_\_\_\_  
Describe Reaction \_\_\_\_\_ Treatment \_\_\_\_\_

Food Allergy Yes/No Food \_\_\_\_\_  
Describe Reaction \_\_\_\_\_ Treatment \_\_\_\_\_

Bee Sting Allergy Yes/No Treatment \_\_\_\_\_  
Describe Reaction \_\_\_\_\_

Asthma Yes/No Treatment \_\_\_\_\_  
Describe Reaction \_\_\_\_\_

**REGULAR OR EMERGENCY MEDICATIONS NEEDED: (Complete if not in violation of confidentiality)**

\_\_\_\_\_

Has your child been exposed to any communicable disease within the past three weeks? Please explain:

\_\_\_\_\_

Recent surgery or serious injury: \_\_\_\_\_

Chronic or recurring illness or condition: \_\_\_\_\_

**MEDICAL COVERAGE:**

NAME OF INSURANCE COMPANY \_\_\_\_\_

POLICY OR CERTIFICATE NUMBER \_\_\_\_\_ PHONE# \_\_\_\_\_

\_\_\_\_\_ DATE

\_\_\_\_\_ PARENT'S SIGNATURE

**PLEASE NOTIFY US OF ANY CHANGES**