CLIENT'S NAME_____

IENT'S MEDICAL NUMBER_____

CLIENT'S SOCIAL SECURITY #_____

MEDICAL CARE POLICY

Every entrant into the KIDS HELPING KIDS program will receive a complete physical examination and laboratory tests to screen for any physical problems. Charges to cover the physician and laboratory fees for this initial exam are included in the Program Fee. If any problems are discovered or additional tests indicated or medication prescribed, you will receive a report, recommendations, and charges to cover prescriptions. Non-essential medical or dental care during the first two phases is discouraged. No medications, patent or prescriptions, may be given without permission of staff.

In the event that an urgent medical problem arises while the client is in attendance at the program or in a temporary home, the client will be taken to the Emergency Room of St. Elizabeth Hospital, South. The parent(s) will be notified as soon as possible. You will receive a bill for services rendered.

If a client who is enrolled in KHK experiences a medical condition requiring recurring doctor visits, physical rehabilitation or any treatment away from the program, the client will receive a medical discharge from KHK and the parents must accept full responsibility for seeing that their child receives proper medical treatment. After the treatment is concluded the parents will bring to KHK a written physician's statement saying that the client is physically able to participate in all phases of the KHK program. This written statement will disclose the medical problem involved and the treatment provided. The child is officially enrolled back into KHK after the medical staff gives their approval.

ve) hereby confirm that my child has a complete and up-to-date immunization record as required by law.

I (we) understand and agree to the medical policy.

I (we) hereby authorize medical care at one of the available Emergency Rooms when determined necessary by the staff at KIDS HELPING KIDS for my (our) child.

Is your child allergic to anything? If so, please list: _____

_____ _____

X SIGNATURE RELATIONSHIP/DATE * Name of INSURANCE COMPANY

_____ _____

X SIGNATURE RELATIONSHIP/DATE * POLICY #/ PHONE # of Insurance Company

_____

* SOCIAL SECURITY #'s of responsible party/parties

* * * * * *

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 19____.

_____

Notary Public My Commission Expires