Medical Accommodation Consent and Release
SUU Head Start

I,_____ wish my child,_____ to attend SUU Head Start. I understand that my child has a medical condition that requires intervention and assistance from SUU Head Start employees. I understand that Southern Utah University, Head Start directors and employees, and the State of Utah shall not be, nor later become liable or responsible in any way in conjunction with services provided while participating in this program including any adverse reaction suffered by the student as a result of taking prescribed medication.

In case of emergency, I hereby give my consent for a qualified physician to perform any medical procedures he/she deems necessary for my child while participating in this program. It is understood that SUU Head Start employees and medical personnel will make the necessary attempts to contact me or an authorized "Person to Contact" should the need arise. I, the undersigned, do assume and agree to pay (if connected to a preexisting medical condition) physician fees, hospital charges or ambulance fees for services provided to my child.

The attached instruction from a physician for administration of prescribed medication includes procedures for missed medication and adverse symptoms.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Witness Signature Date

_____ _____
Witness Signature Date

_____
Child's Physician Phone number

Person to Contact

_____
Name Relationship Phone number

_____
Name Relationship Phone number