Colonial Sports
PHYSICAL, MEDICAL & DIETARY INDIVIDUAL ACTION PLAN

Child's Name _____ Person Filling Out Form: _____

If your child has any **physical, medical, dietary** or other special needs, please note them on this form. If these needs require specific care, we need a copy of the script from the doctor's office before your child starts the program**. If this form does not pertain to your child, please write "none" under each item and sign & date the bottom of the form.**

1. Please state the nature of the physical, medical, dietary or other special need:

2. Please provide signs/symptoms of the need and the course of action to be taken if symptoms are exhibited:

3. In case of an emergency, does your insurance require a specific hospital in the area for treatment? If so, please specify. We will do our best to comply.

4. Please list any medications your child takes on a regular basis. If they need to be administered by our staff, please include a doctor's instructions along with the **original container of medication**. Any prescribed medication, including inhalers and EpiPens, **must be turned in prior to the child's first day of attendance**. ***We do not provide ANY medication including Benadryl, Tylenol, etc. and cannot administer ANY medication without a doctor's written instructions.***

Parent Signature: _____ **Date:** _____