Medical/Assumption of Risks and Permission Slip

Name and Date of Event: _____

Name of Youth Participant:_____

Parent/Legal Guardian Name: _____

Home address: _____

Home phone: _____Cell phone:_____

Business Name: _____

Business Address: _____

Phone: _____

Has this person had any medical problems of which an emergency physician would need to be aware (i.e. but not limited to: asthma, allergy to drugs, food or other, bee stings, chronic illness, headaches, heart ailment, epilepsy, diabetes, physical handicaps, emotional problems, or dietary restrictions)?

YES NO

If "Yes" please list all conditions/allergies (food, medication, bee stings, other) and describe:

Should there be any limits on physical activity? YES NO

At the present time, is this person under a physician's care YES NO
If "Yes" please describe:

List dosage and medications you are sending with your child along with why they are taken and any possible side effects: _____
_____
_____

Date of last Tetanus Booster _____

Are there any over-the-counter medications that you **DO NOT** want administered to your child?
_____
_____
_____

Is this person covered by medical insurance? YES NO
Name of Insurance Company: _____
Policy Number: _____
Name of Insured: _____Relationship to participant: _____
Is pre-authorization required by your insurance company for emergency services?
YES NO
If so, what is the phone number of the insurance company? (___)_____
Name of emergency contact person:_____
Address: _____
Home phone: _____ Cell phone:_____
Business phone: _____
Additional emergency contact: _____
Home phone: _____ Cell phone: _____

PLEASE ATTACH COPIES OF THE FRONT AND BACK OF YOUR CHILD'S INSURANCE CARDS TO THIS FORM.

If this person is below the age of legal consent, (18 years) the law requires that we have your permission to give medical service should the need arise. Please read carefully and sign below.

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all activities except as noted. I hereby give permission to the Leaders of the activity, _____ or his/her designee, to seek routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I request and authorize hospitals and/or other emergency treatment facilities to have access to the information contained in this form in order to provide all necessary medical care for my child while he/she is in attendance at _____ (insert name/date of activity) . I give permission to leaders or his/her designee to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the leader or his/her designee to secure and administer treatment, including hospitalization, for the person named above. I also agree to assume any financial responsibility for my child's care. I agree to the release of any records necessary for insurance purposes. And, under the new HIPPA code, I give permission to release information to leader/designee regarding diagnosis, treatment and necessary prescriptions. I acknowledge that no representations, warranties or guarantees as to results or cures will be made. I also understand that there are inherent risks to my child by participating in this event, even with the best of circumstances. With such knowledge I hereby accept such risks, and having read all of the above information, I hereby give permission for my son/daughter to attend this activity.

I understand that private cars may be used for transportation and I give permission for my son/daughter to be transported by an adult driven vehicle.

I will not hold the sponsoring organizations or any individual participating in making this activity possible, responsible for any mishap in this project.

Print Name:_____ Signed:_____
(Parent or Guardian)
Date:_____