

HEALTH AND MEDICAL RELEASE FORM FOR YOUTH

Name: _____ Date of Birth: _____
Address: _____ Female: _____ Male: _____
City _____ Zip: _____
Parish: _____ City: _____

Is this participant in general good health and able to participate in all activities involved in this event? YES _____ NO _____ (If no, please submit a statement indicating limitations or serious medical conditions.)

Date of most recent physical exam: _____ Physician: _____
Address: _____ Phone: _____

Are there any known allergies to food or medications that those who work with your young person this week should be aware of? Yes No

If Yes, please explain: _____

Are there any known physical, psychological or emotional limitations that would affect this young person's participation in this event? Yes No

If Yes, please explain: _____

Medicines: _____

If any of the above is yes, please submit a statement of how the child has been treated and with what medication. Any medication not able to be self-administered must be listed.

Does the participant have any special dietary needs? If yes please list on reverse side of form.

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I/We, the undersigned, parent(s) of _____ a minor, do hereby authorize as agent(s) **[event staff]** for the undersigned to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act of the medical staff of any licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our for said agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

I agree that in the event my child is injured as a result of his/her participation in this event, including transportation to and from such activity through the negligence (active or passive) of the **[Parish name]**, or any of any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any accident, hospital, medical insurance, or any available benefit plan of mine or my spouse.

I also, give my child permission to self-medicate except for medications which are listed on the back of this form. I understand that any medications so listed will be dispensed by the Director of First Aid for the **[event]**.

This authorization shall remain effective from **[time/days of event]**.

Signature of parent(s)/Guardian: _____

Date: _____

Emergency Telephone Number During Event_ _____

Alternate Telephone_ _____

Family Health Insurance Co: _____

Policy No.: _____

(If possible please provide a copy of the insurance card)