



Staff Use ONLY

Center: _____

Effective Dates (12-mth)

Medical Information/Release Form

The intent of the completed information in this form is to provide Youth First personnel with appropriate background information to administer appropriate care to the participant named below while he/she is attending program. The persons listed here will be contacted to assist in medical/behavioral problem solving. All medications must be in original pharmacy containers with labels.

PARTICIPANT INFORMATION

First Name _____ Last Name _____ M.I. _____
Address _____ City _____ Zip _____
Home Phone () _____ Cell Phone () _____
Gender Female Male Date of Birth ____ / ____ / ____

MEDICAL EMERGENCY CONTACT INFORMATION

| | |
|--------------------------------|--|
| <u>Person to Contact First</u> | <u>Backup Contact (Relative or Friend)</u> |
| Name _____ | Name _____ |
| Relation to Participant _____ | Relation to Participant _____ |
| Daytime Phone () _____ | Daytime Phone () _____ |
| Evening Phone () _____ | Evening Phone () _____ |
| E-mail _____ | E-mail _____ |
| Primary Health Clinic _____ | Clinic Phone () _____ |

Do you carry family medical/hospitalization insurance? Yes No

Provider: _____ Policy/Group # _____

GENERAL HEALTH INFORMATION

Does the child have any of the following conditions or a history of any of the following conditions? (**Check all that apply**)

| | | |
|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Heart or cardio-vascular problems/disease |
| <input type="checkbox"/> Convulsions/seizure | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Chronic bone, muscle or joint injuries |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Other condition(s): _____ | |

Allergies or reactions: (**Check all that apply**)

| | | | | |
|---|---|---|---------------------------------|----------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Dairy | <input type="checkbox"/> Gluten | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Insect bites or stings | <input type="checkbox"/> Ivy/oak/sumac toxins | <input type="checkbox"/> Other (list) _____ | | |

(OVER)

MENTAL/EMOTIONAL HEALTH

- My child has NO remarkable mental, social or emotional health needs
- My child has the following concerns:
 - Diagnosed with Attention Deficit/Hyperactivity Disorder (ADD or ADHD)
 - Psychiatric diagnosis such as depression, OCD, panic/anxiety disorder
 - Has an emotional health concern
 - Has a learning disability
 - Has seen or is currently seeing a professional for mental/emotional health concerns

MEDICATIONS

Is your child currently on any prescribed or over-the counter medication?

Condition: _____ Name of Medication _____

Dosage: _____ Time(s) of day: _____

Physician Name: _____ Physician Phone: () _____

Condition: _____ Name of Medication _____

Dosage: _____ Time(s) of day: _____

Physician Name: _____ Physician Phone: () _____

Other Medical Concerns/Disabilities/Special Needs: _____

TO BE READ AND SIGNED BY PARENT/GUARDIAN

MEDICAL AUTHORIZATION

I recognize that participation in recreation and instruction activities, even when well supervised and managed, poses a risk to my child and I agree to assume such risk on behalf of my child. I, the undersigned, hereby hold Youth First, its employees and agents harmless from liability for any and all medical and/or accident expenses that my minor child may incur during their involvement in Youth First programs and activities. This health history is correct so far as I know, and the person herein described has permission to engage in all activities except as noted.

AUTHORIZATION FOR TREATMENT

If an injury or other medical condition occurs or arises, I hereby give permission to Youth First staff to provide emergency first responder services; to administer over-the-counter and prescription medications as directed by a parent; to release any records necessary for insurance purposes; and to provide or arrange necessary related emergency transportation for my child. In an emergency or in the event I cannot be reached, I hereby give permission to the physician selected by Youth First to secure and administer treatment, including hospitalization, for the person named above. I understand that I am financially responsible for charges and hereby guarantee full payment to the attending physicians or health care unit. In the event of an emergency where I cannot decide for my child, I give permission to the physician/hospital selected by Youth First staff to secure and administer treatment for my child, including hospitalization.

Parent/ Guardian SIGNATURE

Date

Parent/Guardian PRINTED Name