

# MEDICAL RELEASE FORM

NAME \_\_\_\_\_

GENDER \_\_\_\_\_ Male \_\_\_\_\_ Female

DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

ADDRESS \_\_\_\_\_

CITY STATE/PROV ZIP \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

EMAIL \_\_\_\_\_ PHONE \_\_\_\_\_

## MEDICAL INSURANCE

INSURANCE COMPANY NAME or CANADIAN HEALTHCARE NUMBER \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

CITY STATE/PROV ZIP \_\_\_\_\_

PHONE \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_

POLICY # \_\_\_\_\_

PHYSICIAN PHONE \_\_\_\_\_

## DENTAL INSURANCE (if different than medical insurance listed above)

INSURANCE COMPANY NAME \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

CITY STATE/PROV ZIP \_\_\_\_\_

PHONE \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_

POLICY # \_\_\_\_\_

## MEDICAL INFORMATION

Is your son/daughter currently under the care of a physician for a medical problem? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain...  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your son/daughter currently taking medication prescribed by a physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list each medication and indicate whether or not it needs refrigeration.

\_\_\_\_\_ Requires Refrigeration  
\_\_\_\_\_ Requires Refrigeration

Please list any over-the-counter medications you do not wish dispensed to your child for treatment of minor ailments or injuries.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your son/daughter have any of the following medical conditions? If yes, please explain any details under the condition.

Chronic health problems? \_\_\_\_\_ Yes \_\_\_\_\_ No  
\_\_\_\_\_  
\_\_\_\_\_

Allergies (e.g. food, bee stings, medications)? \_\_\_\_\_ Yes \_\_\_\_\_ No  
\_\_\_\_\_  
\_\_\_\_\_

Program limitations? \_\_\_\_\_ Yes \_\_\_\_\_ No  
\_\_\_\_\_  
\_\_\_\_\_

Is there any other information about your son/daughter that an

attending physician needs to be aware of? Yes No  
If yes, please explain...  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Last Tetanus \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Last MMR \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## PARENTAL CONSENT & MEDICAL RELEASE FORM

\_\_\_\_\_ (Student's name) will be attending DCLA 2006, \_\_\_\_\_ (dates) at the \_\_\_\_\_ (location). As parent(s) we (I) are confident that every measure will be taken to protect the safety of all participants. So on behalf of said student we (I) hereby release, forever discharge, and agree to hold harmless, DCLA 2006, all sponsors, and the directors thereof, from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the participant that occur while said child is participating in DCLA 2006.

Furthermore, we (I) hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in recreation and excursion activities involved therein. Further, authorization and permission is hereby given to DCLA 2006 to furnish any necessary transportation, food and lodging during DCLA.

We (I) are the parent(s) or legal guardian(s) of this participant and hereby grant permission for him/her to participate fully in DCLA 2006, and hereby give DCLA staff permission to take him/her to a doctor or hospital and authorize medical treatment including, but not limited to, emergency surgery or x-rays. We (I) will assume all responsibility for all medical bills, if any are incurred. I understand that if medical treatment is required I will be contacted as soon as possible. Should it be necessary for my child to be sent home for medical reasons, disciplinary reasons, or otherwise, we (I) hereby assume all related costs.

We (I) hereby grant permission for DCLA 2006 to publish images of activities and of this participant for the purpose of promoting DCLA through communications channels of DCLA and its' sponsors. We (I) grant this permission freely without reservation.

Parent /Guardian Name \_\_\_\_\_

Signature Date \_\_\_\_\_

Parent /Guardian Name \_\_\_\_\_

## EMERGENCY CONTACT

In case of emergency, please contact...

Name \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_

Phone \_\_\_\_\_