Full Name of Participant: ____

Christodora's
New Youth Conservationist Program

Medical Release Form

New
Youth
Conservationists

This form must be completed and Signed by parent/guardian to participate!

➔➔Please attach a copy of the front and back of health insurance card. ←←

The following information is requested to assist the Christodora-New Youth Conservationist Program in providing appropriate care for your youth. As a parent/guardian, you need to complete and sign this form. All personal medical information is handled with confidentiality.

HEALTH HISTORY (circle yes or no)			ALLERGIES (circle yes or no)		
Seizures	yes	no	Food Allergies	yes	no
Convulsions	yes	no	Insect stings	yes	no
Diabetes	yes	no	Medication Allergies	yes	no
Physical Disability	yes	no	Other	yes	no
Chronic Illness	yes	no			
Asthma	yes	no			

If you circled "yes" to any of the above please describe:

____

Please list any specific activities in which your student should be limited:

____

Please list any dietary restrictions:

____

Any other information which teachers should know to provide safe and informed care for your student: ____

Current medication(s):	#1	#2	Example
Medication name	____________	____________	Albuterol inhaler
Dosage/amount	____________	____________	2 puffs
How often	____________	____________	as needed

Please list any and all over the counter medication your student cannot take:

____

Students are responsible for the self administration of any prescribed medication during Christodora-New Youth Conservationist Program operating hours.

EMERGENCY AUTHORIZATION

By signing below, I hereby give permission for the staff of Christodora and the New Youth Conservationist Program, herein called Program Staff, to administer standard first aid to my youth, including over the counter medications, **subject to the restrictions I have listed above**. I hereby authorize my youth to carry and self-administer all prescription medications I have provided for my youth while participating in the Christodora New Youth Conservationist Program, including his/her own metered dose inhalers and/or epi-pens as currently prescribed by a licensed health care professional. In the event I cannot be reached in an emergency, I hereby give my permission for the Program Staff to select a physician for my youth and to authorize necessary X-rays, tests or proper treatment including hospitalization, anesthesia and/or surgery for my youth as named above. In the event I cannot be reached in an emergency, I hereby give my permission for the Program Staff to select a physician for my youth and to authorize necessary and proper treatment including hospitalization, anesthesia and/or surgery for my youth as named above.

Signature of parent/guardian________________________________**Date**______________

Name ______________________________

Address ____

Telephone- Home ( )_____________Cell( )_____________Work ( ) _____________

In the event that I cannot be reached in the case of an emergency please notify:

Name______________________________/Relationship to Student________________

Address ____

Telephone- Home ( )_____________Cell( )_____________Work ( ) _____________