

Youth in Philanthropy

Medical Information/Release Form (Youth)

Due By September 24, 2011 at the Orientation Day

PARTICIPANT INFORMATION

Participant's Name _____

Permanent Address _____

City, State, Zip _____

Date of Birth _____ Gender _____

Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to Contact First

Name _____

Relation to Participant _____

Daytime Phone _____

Evening Phone _____

Name of Family Doctor _____

Name of Dentist _____

Backup Contact (Relative or Friend)

Name _____

Relation to Participant _____

Daytime Phone _____

Evening Phone _____

Office Number _____

Office Number _____

INSURANCE POLICY INFORMATION

The above-named participant is covered by health insurance. Yes** No*

* If no, initial this line stating that you do not have health insurance and are aware that Enhance Hamilton County Foundation and/or Power Up YOUth does not carry any health insurance for you. _____

** If yes, provide the following information

Policy Holder's (P.H.) Name _____ P.H.'s Date of Birth _____

Address _____ Relation to Participant _____

City, State, Zip _____ Occupation _____

P.H.'s Employer's Name/Address _____

Insurance Company Name _____

Policy # _____ Plan # _____

Health Information (Please Print)

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): (Please list) _____ | |

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) _____ | | |

Is your child currently on any prescribed or over-the counter medication? (If so, please record the condition/ailment, name of medication, dosage, time(s) of day, prescribing physician.)

.....

Date of last tetanus shot (approximate if necessary): _____

(over)

TO BE READ AND SIGNED BY PARTICIPANT

BEHAVIOR EXPECTATIONS OF THE PARTICIPANT

It is important to follow the directions of the adult leader(s) at all times. I understand that as a participant I have the responsibility to help make the activity a safe experience for everyone through my behavior and conduct. I also understand the danger of not following rules and directions and agree to follow them.

_____ Participant Signature

_____ Date

TO BE READ AND SIGNED BY PARENT OR GUARDIAN

I understand that my child must be healthy and reasonably fit in order to safely participate in activities, and that I will inform the program leader(s) of any medication, ailment, condition, or injury that may affect his/her ability to participate safely.

MEDICAL EMERGENCY PARENTAL PERMISSION*

The health history for my child is correct and complete to my knowledge. If an injury or other medical condition occurs or arises, I hereby give permission to the Enhance Hamilton County Foundation, Community & Family Resources, ISU Extension, and/or CAPP Program staff or volunteer involved in the Youth in Philanthropy Program to provide routine health care and seek emergency treatment including x-rays or routine tests. I agree to the release of any record necessary for treatment, referral, billing or insurance purposes. 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 the Enhance Hamilton County Foundation, Community & Family Resources, ISU extension, and/or CAPP program staff or volunteer to secure and administer treatment for my child, including hospitalization.

_____initial _____date

PUBLICITY/IMAGE/VOICE PERMISSION

The Enhance Hamilton County Foundation, Community & Family Resources, ISU extension, and/or CAPP Coordinator normally takes photographs, video, and/or tape recording of our programs. During Youth in Philanthropy activities, a photograph or video/audio recording may be taken of you or your child. Unless you request otherwise, your initial below will be considered permission to photograph, film, audio/video tape, record and/or televise your image and/or voice or the image and/or voice of your child for use in any publications or promotional materials, in any medium now known or developed in the future without any restrictions. If you object to Enhance Hamilton County Foundation, Community & Family Resources, and/or CAPP Coordinator using you or your child's image or voice in this manner while involved in the Youth in Philanthropy Program, please notify the adult leader.

_____initial _____date

TRANSPORTATION

I am giving my permission for my child to be transported to and from Youth in Philanthropy Program, Enhance Hamilton County Foundation, Community & Family Resources, ISU Extension, and/or CAPP Coordinator activities, meetings, and/or events. I give my permission for: **(Check all that apply.)**

- My child to ride with any adult volunteer driver.
- My child to ride with an authorized adult volunteer driver who has completed an MVR check.
- My child to ride in another youth's (18 or younger) vehicle to Youth in Philanthropy activities.
- My child to drive his/her vehicle to Youth in Philanthropy activities or events.
- My child to transport other participants in his/her or my vehicle.

I understand that if personally-owned vehicles are used as transportation to and from Youth in Philanthropy Program and/or Power Up YOUth events or activities, that the owner of the vehicle is responsible for any liability that might occur during the transportation. The participating agencies do not provide coverage for any property damage, personal injury or liability that may occur while using personal vehicles. Vehicle owners are required to carry automobile liability insurance as required by the State of Iowa.

_____initial _____date

Youth in Philanthropy ASSUMPTION OF RISK AND RELEASE OF LIABILITY

(Please read carefully.)

I give permission for _____ to participate in the Youth in Philanthropy Program. I understand that project activities/events may involve certain risks of physical activity and possible injury and that the Youth in Philanthropy Program staff will provide each participant with reasonable care, but that they cannot guarantee that my child will remain free of injury. I nonetheless wish to have my child participate in the program and ASSUME the RISK of participating. I agree to RELEASE from LIABILITY, INDEMNIFY and HOLD HARMLESS the Youth in Philanthropy Program staff and their officers, employees and agents (hereinafter the RELEASEES) from any and all claim and/or cause of action arising out of and related to any injury, loss, penalties, damage, settlement, costs or other expenses or liabilities that occur as a result of my child's participation in the program. This release, however, is not intended to release the above-mentioned RELEASEES from liability arising out of their sole negligence.

_____ Parent or Guardian Signature

_____ Date

(Must be signed by the parent or guardian if the participant is under 18 years old)

Please include any additional information or comments in the space provided below: