Pennsylvania Southeast Conference
Spring Meeting
June 6, 2015

Child Care Medical Release Form
(complete one per child)

Name of Child: ____ **Birthdate of Child** ________________

1. Has this person had any medical problems of which an emergency physician would need to be aware (i.e. but not limited to: asthma, allergy to drugs, food or other, chronic illnesses, headaches, heart ailment, epilepsy, diabetes, physical handicaps, emotional problems, or dietary restrictions)? ☐**YES** ☐**NO**
2. Should there be any limits on physical activity? ☐**YES** ☐**NO**
3. At the present time, is this person under a physician's care? ☐**YES** ☐**NO**
   If "Yes," please describe:
   ____
   ____
4. Is this person taking any medication? ☐**YES** ☐**NO**
   If "YES," list names, dosage, why taken, and any side effects:
   ____
   ____
5. Is this person covered by medical insurance? ☐**YES** ☐**NO**
   Name of Insurance Company: ___________________________________
   Policy number: #____
   Name of Insured: ____
   Relationship to participant: ___________________________________
6. Does your insurance company require pre-authorization for emergency services? If so, phone number of the insurance company? ☐**YES** ☐**NO**
   (   ) _________________

This person is below the age of legal consent, (18 years); the law requires that we have your permission to give medical service should the need arise. Please read carefully and sign below.

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all activities except as noted.

I hereby give permission to the adult leaders of the PSEC Spring Meeting to seek routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I give permission to the PSEC to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the PSEC to secure and administer treatment, including hospitalization, for the person named above. I also agree to assume any financial responsibility for my child's care. I agree to the release of any records necessary for insurance purposes. I also understand that there are inherent risks to my child by participating in this event, even with the best of circumstances. With such knowledge I hereby accept such risks, and having read all of the above information, I hereby give permission for my son/daughter to attend the PSEC Spring Meeting.

______________________________________	______________________________
(1st Contact - Parent or Guardian-PLEASE PRINT)	(Cell phone number that you can be reached on the day of the meeting)
______________________________________	______________________________
(Parent or Guardian Signature)	(Date)
______________________________________	______________________________
(2nd Contact - Parent or Guardian-PLEASE PRINT)	(Cell phone number that you can be reached on the day of the meeting)