Pennsylvania Southeast Conference

Fall Meeting 2017

**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 **YES NO**

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)?

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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4. Is this person taking any medication? **YES NO**

If "YES," list names, dosage, why taken, and any side effects:

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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 **YES NO**

services? If so, phone number of the insurance company?

( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***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 Fall 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 Fall Meeting.*

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

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(Parent or Guardian Signature) (Date)

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