INTERNATIONAL YOUTH INITIATIVE MEDICAL RELEASE FORM

Participant Legal Name:____

Event(s):______________________________ Date(s):____________________

TREATMENT RELEASE:

Permission is hereby granted for any available and appropriate medical attendant or doctor to perform whatever care is necessary for the my welfare or the welfare of the above-named participant until International Youth Initiative staff are able to contact personally my/the participant's family or I am able to make my own decisions (if 18 years or older).

__________ Date ______________________ Signature of Participant

__________ Date ______________________ Legal Name of Parent/Legal Guardian ______________________ Signature of Parent/Legal Guardian

__________ Date ______________________ Legal Name of Parent/Legal Guardian ______________________ Signature of Parent/Legal Guardian

IN CASE OF EMERGENCY OR INJURY, PLEASE CONTACT:

Primary Contact Name:______________________________ Relationship:________________

Phone #1: (_______) ____________________ Phone #2 : (_______) ____________________

Secondary Contact Name:______________________________ Relationship:________________

Phone #1: (_______) ____________________ Phone #2 : (_______) ____________________

PHYSICIAN & INSURANCE INFORMATION:

Primary Care Physician:____________________________ Phone: (_______) ____________________

Insurance Company:____________________________ Phone: (_______) ____________________

Policy Number:________________________ Name of Insured:____________________________

Does your insurance cover international medical treatment? Yes_____ No____

HEALTH HISTORY:

______Drug Allergies ____________________ ______Heart Condition ______Behavior/Nervous Disorder

______Food Allergies ____________________ ______Asthma ______Physical Handicap

______Environmental Allergies______________ ______Seizure Disorder ______Stomach Problems

______Insect Stings______________________ ______Diabetes ______Other

If any of the above are checked, please give details (i.e. include normal treatment of allergic reactions):

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Date of last tetanus shot:________________ Name, dosage, and frequency of any medications that must be taken regularly, or as needed:____

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Any swimming restrictions: Yes_____ No_____ Any activity restrictions: Yes_____ No_____ If yes, please explain:

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Additional medical information that may be pertinent to care/participation in event(s):__________________

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