

# PARENT/GUARDIAN'S CONSENT AND MEDICAL RELEASE FORM

I, \_\_\_\_\_ (parent/guardian name) am the parent or legal guardian of \_\_\_\_\_ (youth name). I give my consent for him/her to attend *General Assembly 2008, June 25<sup>th</sup> – June 29<sup>th</sup>, 2008 in Ft. Lauderdale, FL*, hereafter known as "THE EVENT". I give my consent and authority for the UUA staff or designated adult to take action to help insure the safety, health and welfare of my son/daughter/ward. I understand that if s/he breaks any federal/state/provincial or local laws, s/he will be asked to leave THE EVENT and I will be informed. I also request and empower the UUA staff to authorize medical personnel and hospitals to provide all medical care, including but not limited to hospital tests, emergency surgical care, pathology, radiology and anesthesia, surgery and prescriptive drugs for the health of my child.

### The child covered by this authorization is:

Full Name \_\_\_\_\_ Age: \_\_\_\_\_  
Parent/Legal Guardian \_\_\_\_\_  
Home Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Business Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

### In Case of Emergency during THE EVENT Contact:

Name \_\_\_\_\_  
Day Phone \_\_\_\_\_  
Evening Phone \_\_\_\_\_

### Medical / Health Problems:

Allergies \_\_\_\_\_  
Asthma/Respiratory \_\_\_\_\_  
Vision/Hearing \_\_\_\_\_  
Surgery \_\_\_\_\_  
Heart Problems \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Seizures \_\_\_\_\_  
ADD \_\_\_\_\_  
Headaches \_\_\_\_\_  
Stomach \_\_\_\_\_  
Broken bones \_\_\_\_\_  
Other \_\_\_\_\_

Individuals not immunized due to religious objection must submit a written and signed statement from parent/guardian stating objection to their child's immunization due to religious beliefs. Youth not immunized due to medical exemption must submit a statement signed by a physician.

### Health Care Information:

Name of Dentist/Orthodontist \_\_\_\_\_  
Phone \_\_\_\_\_  
Name of Doctor \_\_\_\_\_  
Phone \_\_\_\_\_  
Do you carry family medical/hospital Insurance?  
 yes  no  
Name of parent/person with insurance policy \_\_\_\_\_  
Health Insurance Agency Name \_\_\_\_\_  
Policy # \_\_\_\_\_  
Group # \_\_\_\_\_

Medications currently taking:

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

All youth requiring prescription medicine while at THE EVENT need to check in with THE EVENT nurse upon arrival. All medicine will be kept locked in the health center area and distributed under the supervision of the nurse. Asthma inhalers and epi-pens prescribed for severe allergic reaction may be carried, but please check with the nurse upon arrival so that these medications may be checked and documented. Please bring medicines to THE EVENT in the original prescription bottle or container. Youth wishing to take nonprescription medicine such as Tylenol or ibuprofen should also check this medicine in with the THE EVENT nurse along with written instructions and consent from parent/guardian.

Is your child under the care of a physician for  
Epilepsy?  yes  no Diabetes?  yes  no

Other \_\_\_\_\_

The Undersigned, on his/her own behalf, and on behalf of her/his minor child/ward, does hereby RELEASE, discharge and covenant to hold harmless the Unitarian Universalist Association, its officers, employees and volunteers, from any and all claims, causes of action, and liability of any kind or nature, including personal injuries or death, or in any way arising out of, directly or indirectly, the child's / ward's attendance or participation in THE EVENT.

**Parent/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_