MEDICAL RELEASE FORM Monthly Meeting _____

SOUTHERN APPALACHIAN YOUNG FRIENDS (SAYF)

Young Friend: _____Date of Birth_____

Parent or Legal Guardian: _____

Address:_____

_____

Phone #s during the retreat (home. Work, cell):_____

Emergency number (and name) if parent cannot be reached: _____

I give permission for my minor child to attend Southern Appalachian Young Friends retreats. In the event of an emergency, I authorize the adult leaders of SAYF to act for me to make any and all decisions for me concerning the medical treatment or hospitalization of my minor child; to consent to any X-Ray examination; medical, dental, or surgical diagnosis; treatment; and hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at a doctor's office or in a hospital. I specifically request that an adult leader accompany my child during any evaluation and treatment to the same extent as I would as a parent and guardian unless my child requests otherwise for reasons of privacy. I expect to be contacted as soon as possible. I absolve the adult leaders from personal liability arising from the exercise of such authority, including any and all costs, expenses, and charges for medical or hospital care provided by or received from whomsoever, and costs of transportation related thereto. I affirm that the following insurance and medical information is complete and correct.

All participants of SAYF retreats, young Friends and adults are required to have been fully vaccinated prior to attendance. Full vaccination is considered: 2 weeks after a second dose in a 2-dose series, such as the Pfizer or Moderna vaccines, or 2 weeks after a single-dose vaccine, such as Johnson & Johnson's Janssen vaccine.

I hereby affirm that my minor child attending SAYF has been fully vaccinated against Covid-19.

Signature of Parent or Guardian:_____ Date_____

Insurance Company name & address:

_____

Phone number_____ Policy number_____ Policyholder:_____

Family doctor (and phone #):_____

Current prescriptions (please keep us up-to-date!): _____

_____

Current medical or psychological conditions, allergies, etc _____

_____

Other information that adult leaders and/or emergency room physician should know: _____

_____

PLEASE DON'T FORGET TO FILL OUT PAGE 2 OF THIS FORM!

Young Friend's Name_____

Dietary Needs:

☐Vegetarian ☐Vegan ☐Gluten-free ☐Dairy-free ☐Other _____

There may be times when your child suffers from mild symptoms that can be treated with simple over the-counter medications that we have available in our first aid kit.

If you give permission for your child to receive the following medications, check the yes column. If that column is not checked, then permission is not given.

Yes to all medications below: _____

Yes:_____ Acetaminophen (Tylenol)
Yes:_____ Ibuprofen (Motrin)
Yes:_____ Antihistamine (Benadryl)
Yes:_____ Pseudoephedrine for colds
Yes:_____ Combined Sudafed & anthistamine (Actifed)
Yes:_____ Arnica (homeopathic)
Yes:_____ Emetrol for nausea
Yes:_____ Mylanta, Pepcid AC, Tums
Yes:_____ Pink bismuth (Pepto Bismol)
Yes:_____ Topical antibiotic ointment
Yes:_____ Calamine Lotion
Yes_____ Stingeaze 5% benzocaine
Yes: ____ Arnica ointment
Yes:_____ Nasal Spray (oxymetazone)
Yes:_____ Anti itch Cream (hydrocortisone/pramoxin antiseptic)
Yes:_____ Epi-Pen, for anaphyllactic reactions: only in severe emergency & followed by mandatory evaluation in Emergency Dept.

Time & Date Given (for use by retreat FAN)

Information on Tetanus Shots

Date last shot: Don't know_____ Less than 5 years_____ 5 -10 years:_____ Over 10 years _____ Is your child is allergic to tetanus:_____ yes _____ no _____ If there is an accident for which a tetanus shot is recommended, may we authorize it? Yes_____

Does your child have asthma? Yes____ No____ If yes, please answer the following questions:

Does your child use a daily medication? If yes, please list the medication(s) and the dosage(s):

_____

How often does he/she experience an asthma attack? _____

Has your child ever been hospitalized because of asthma? _____

Is your child able to recognize and treat the onset of an attack? _____

Can your child recognize when the attack is severe and requires medical attention? _____

How should we respond to a breathing problem with your child?

_____