



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

STUDENT Medical Release Authorization

Team/Delegation/School _____

Full Name of Student _____

Address _____

City _____ Zip _____

Email _____ Home Phone _____

Date of Birth _____ Sex _____ Age _____ Grade _____

Medical Insurance _____

Policy Number _____

Dental Insurance _____ Policy Number _____

Parent or Legal Guardian's Name _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Secondary Emergency Contact's Name _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Date of last Tetanus (or DTP) immunization _____

Does the student have any allergies (drug, animal, food, etc.) or other health problems that YMCA Staff or emergency medical staff should know about?

Does the student carry medication? _____

If student does carry medication:

What is the condition being treated? _____

What medication is being taken? _____

What are potential side effects? _____

How often does student take medication and at what dose? _____

In the event that the child named above is injured or becomes seriously ill and I cannot be reached, I authorize the YMCA Youth Legislature advisor or staff to seek and authorize any hospitalization, medical, dental and/or surgical treatment that is deemed advisable by the circumstances.

Signature of Parent or Legal Guardian _____ Date _____