

**MEDICAL RELEASE FORM
SOUTHERN APPALACHIAN YOUNG FRIENDS (SAYF)**

Young Friend: _____ Date of birth: _____

Parent or legal guardian: _____

Address: _____

Phone numbers during the retreat (home,work,cell,pager): _____

Emergency phone 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 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.

Signature of parent or legal guardian: _____ Date: _____

Insurance company: _____

Address: _____

Phone number: _____ Policy number: _____

Policy holder: _____

Family doctor (and phone number): _____

Prescriptions currently taken (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!

To the parent,

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. Please take a moment to place an X below to indicate your willingness for your child to receive the following medications when necessary to make him or her more comfortable (we have provided some brand names to help you recognize the generic names we have listed):

- Yes: ___ No: ___ Acetaminophen (Tylenol) for pain or fever
Yes: ___ No: ___ Ibuprofen (Motrin) for pain or fever
Yes: ___ No: ___ Antihistamine (Benadryl) for itching, colds, or bee stings
Yes: ___ No: ___ pseudoephedrine hydrochloride (Sudafed) for colds
Yes: ___ No: ___ combination Sudafed and antihistamine (Actifed)
Yes: ___ No: ___ Immodium for diarrhea
Yes: ___ No: ___ Emetrol for nausea (a sugary syrup that can sometimes help)
Yes: ___ No: ___ Mylanta or Pepcid AC for indigestion
Yes: ___ No: ___ Pink bismuth (Pepto Bismol) for nausea and vomiting
Yes: ___ No: ___ Topical antibiotic ointment
Yes: ___ No: ___ Primatine Mist (used only in emergency situations when an allergic reaction has impaired breathing)
Yes: ___ No: ___ Epi-Pen, epinephrine kit for anaphylactic reactions: only in severe emergencies, and followed by mandatory evaluation in Emergency Dept.

Information on Tetanus shots

Date last shot: _____ Don't know: ___ Less than 5 years: ___ 5-10 years: ___

Over 10 years: ___ My child is allergic to tetanus: ___

If there is an accident for which a tetanus shot is recommended, may we authorize it to be given? Yes: ___ No: ___

If your child has asthma, 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 the attention of medical professionals? _____

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

