YOUTH MEDICAL & PHOTO RELEASE FORM

Youth's Name _____ M __F__ Age _____ Birth date _____

YOUTH E-mail _____ YOUTH Cell Phone ( ) _____

Parent/ Guardian Name(s) _____

Address _____

City _____ State _____ Zip _____ E-mail _____

Parent/Guardian Cell Phone ( ) _____ Home Phone ( ) _____

Alternate Emergency Contact Person: _____ Relationship: _____

Home Ph ( )_____ Cell Ph ( ) _____

Health Insurance Co._____ ID/Policy No._____ Group No._____

Name of primary care physician _____ Phone ( ) _____

Describe any special needs the young person may have: _____

List any medications the young person is currently taking or have been taking in the last year

_____

List any medication the young person is allergic to_____

What kind of reaction? _____

Is there any non-prescription medications you **DO NOT** want the young person to receive?_____

Has the young person had a tetanus shot in the past five years? Yes_____ No_____

Has he/she ever had hepatitis? Yes_____ No_____

MEDICAL CONSENT AND AUTHORIZATION: The young person herein described has permission to participate in the Annual Conference Session 2019. In the event of an emergency or non-emergency situation requiring medical treatment of the young person during his/her attendance at Annual Conference Session 2019, I/We the undersigned parent(s)/guardian(s) of the young person, give the Conference Leadership my/our consent and authorization for all medical treatment that is deemed necessary by qualified medical personnel for the proper care and treatment of the young person, including but not limited to administration of first-aid, use of an ambulance, x-ray examination, administration of anesthesia, surgery and hospitalization.

CIRCLE THOSE THAT APPLY AND EXPLAIN AS NECESSARY

Allergies	Ear Infections	Dietary Restrictions	Bronchitis
Asthma	Eye/Vision Impairment	Ear/Hearing Impairment	Hypertension
Learning Disability	Braces	Fainting	Convulsions/Epilepsy
Nose Bleeds	ADHD	Anxiety	Insect Stings
Bleeding/Clotting Disorder	Depression	Heart Defect/Disease	Diabetes
Homesickness	Bed Wetting	Sleep Disorders/Sleep Walking	

Explanation: _____

_____

Chronic or reoccurring illness _____

Disabilities: _____

Please list any other condition requiring medication, special care, or special diet on separate page.

PHOTO AND VIDEO AUTHORIZATION:

( ) I give permission for still or video pictures of my child to be used by Susquehanna Conference for promotional purposes.

( ) I do not give permission for still or video pictures of my child to be used by Susquehanna Conference for promotional purposes.

PERSONAL COMMUNICATION AUTHORIZATION:

( ) I give permission to adult chaperones of Annual Conference to contact my child directly for event communication purposes.

( ) I do not give permission to adult chaperones of Annual Conference to contact my child directly for event communication purposes.

Parent/Guardian Signature: _____ Date Completed: _____

Parent/Guardian Name (please print): _____

Relationship to Young Person: _____