

(NOTE: If your youth needs to take either prescribed or over the counter medication while participating in this special event; the medication/s must be given to the leader in charge of the event in their **original** bottle/s. The leader will dispense these medications to the youth according to the directions on the bottle of prescribed medications or at times supplied by you if it's an over the counter medication. **Exception:** Youth that need an epi-pen or inhaler may keep them and use them as needed. Leaders need to be made aware that the youth has them with her/him. Leaders also need to be informed if the youth has had to use them.

Is there any additional information about your youth's physical or emotional health, or any condition that has not been disclosed in this form, which you think is important for the counselors to know? If yes, please explain. All information will be kept strictly confidential. _____

Medical attention for my youth is covered under the following insurance policy:

Provider name _____ Plan type _____
Insured Holder's name _____ Policy # _____
Family Physician _____ Phone _____
Dentist/Orthodontist _____ Phone _____
Dental Insurance Provider _____ Policy # _____
Specialist _____ Phone _____

MEDICAL AUTHORIZATION

If professional medical is required, I may be contacted at one of the following phone numbers:

Home _____ Work _____ Other _____

In the event that reasonable attempts to reach me have been unsuccessful and reasonable attempts to reach my child's physician have been unsuccessful, I give my consent for the administration of any treatment deemed necessary by a licensed physician or doctor and the transfer of my child to any reasonably accessible hospital or health care facility.

This authorization does not cover any major surgery unless the medical opinions of two licensed physicians or doctors, concurring in the necessity for such surgery, are obtained before the surgery is performed.

Signature of Parent or Guardian Date _____

TRANSPORTATION HOME

If it becomes necessary for my youth to come home for any medical or disciplinary reason, I agree to provide transportation and do so at my own expense.

Signature of Parent or Guardian Date _____

Acknowledgement of Participant Date _____

EMERGENCY CONTACT

In the event that I cannot be reached, the following person is to be contacted:

Name _____ Phone _____

State of Ohio _____) ss
County of _____

*Before me, a notary public, in and for said state, personally appeared the above named _____
who acknowledged that he/she did sign the forgoing instrument and that the same is his/her free act and deed.*

*In testimony Whereof, I have hereunto affixed my name and official seal at _____, Ohio this _____ day of
_____, 20 _____.*

(Signed)_____