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MEDICAL AUTHORIZATION



PLEASE COMPLETE BOTH SIDES!

Name of Children:

In consideration of my child's participation in the Homeschool Christian Youth Association (HCYA) program: I hereby authorize, in the event my child suffers injury, any director, coach, medical attendant, or adult leader of the HCYA program to consent to emergency medical treatment for my child when I cannot be contacted to so consent. Such medical treatment may include, without limitation, x-ray examination, anesthetic, medical, surgical examination or treatment and general hospital care. No prior determination of life threatening emergency or danger of serious or permanent injury resulting from delay of treatment need be made under this authorization. EXCEPT AS NOTED BELOW, this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, and is given to provide authority and power on the part of a supervisor or medical attendant of the HCYA program to give specific consent to any and all such examination, treatment, or hospital care.

Except as indicated below, I specifically give my consent for first aid treatment with bandages and antibiotic ointment (*Neosporin, Neomycin, Mycitracin, Bacitracin, and/or Polymyxin*), Hydrogen Peroxide, Rhuligel, Vaseline, Ibuprofen, Naproxen and/or Tylenol. Homeopathic remedies (arnica gel, calendula cream,) are available as well.

EXCEPTIONS:

I and my child hereby release, absolve and hold harmless the directors, coaches, medical attendant, and adult leaders of the Homeschool Christian Youth Association sports program, and the facility where it is held, from any and all liability for all losses, damages or injuries occurring as a result of my child's participation in the association's activities. I further agree to make or cause to be made, by assignment of third party benefits or otherwise, full and complete payment for examination, treatment or hospital care required in the case of a medical emergency.

I understand that reasonable precautions will be taken to make the program safe and beneficial for all children, but that risk of injury cannot be eliminated entirely, and that this release is necessary for my child to participate in the HCYA program.

I hereby verify that I understand and accept the terms of this Authorization, and that my child is in good physical condition and not limited to participate in any physical activities of the HCYA program except as noted on the back.

Signature of Parent or Legal Guardian:

Date:

_____/_____/_____

PLEASE COMPLETE BOTH SIDES!

STUDENT INFORMATION

Please Print Legibly!

Please put "NONE" OR "N/A" when NOT APPLICABLE

1. STUDENTS

NAME: _____ AGE _____ BIRTHDATE ____ / ____ / ____ SEX: ____

NAME: _____ AGE _____ BIRTHDATE ____ / ____ / ____ SEX: ____

NAME: _____ AGE _____ BIRTHDATE ____ / ____ / ____ SEX: ____

NAME: _____ AGE _____ BIRTHDATE ____ / ____ / ____ SEX: ____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

FAMILY PHONE (____) _____ CELL PHONE: (____) _____

MEDICAL INFORMATION: Please indicate any special limitations, problems, or needs of each student (e.g. existing illness, previous injuries, handicaps, allergies to drugs, limitations on physical activities) Children with Asthma should bring their medication. Additional information may be required for asthmatic children. Please see the first aid person to be sure.

STUDENT: _____ - _____

STUDENT: _____ - _____

STUDENT: _____ - _____

STUDENT: _____ - _____

2. MOTHER'S NAME: _____

ADDRESS (If Different) _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ WORK (____) _____ CELL (____) _____

MOTHER'S EMAIL _____

3. FATHER'S NAME: _____

ADDRESS (If Different) _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ WORK (____) _____ CELL (____) _____

FATHER'S EMAIL _____

4. INSURANCE COMPANY (not required to participate): _____

POLICY HOLDER NAME: _____ SS# _____

EMPLOYER OF POLICY HOLDER: _____

POLICY NO: _____

5. PHYSICIANS NAME _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

PHYSICIAN'S PHONE (____) _____ PHYSICIAN'S HOSPITAL _____

6. PERSON TO CONTACT, OTHER THAN PARENT, IN CASE OF EMERGENCY

HOME PHONE (____) _____ WORK (____) _____ CELL (____) _____