AUTHORIZATION TO ATTEND EVENT

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Please type or print all information. This form must be completed by the parent, legal guardian, or person *in loco parentis* for the youth participant.

Participant

Name _____ Birth Date Month: _____ Day: _____ Year: _____
Last name First name Middle Initial

Mailing Address _____
Street Address City State/Province Postal Code Country

Sex (circle one) F M Height _____ Weight _____ E-mail Address _____

School Name: _____

Emergency Information

In case of emergency, contact: _____ Relationship to participant: _____

Daytime phone _____ Evening/cell phone _____

Alternate contact _____ Relationship to participant _____

Daytime phone _____ Evening/cell phone _____

Medical Information

Health Insurance Company _____ Policy Number _____

Group Name on Insurance Coverage _____

Telephone number or other contact information shown on insurance card _____

Will the participant be taking any prescription medication or over-the-counter drugs of any type? _____

If yes, please explain _____

Has he/she ever been or currently being treated for (circle "Yes" or "No")?

Nervousness?	Yes No	Rheumatic Fever?	Yes No	Asthma?	Yes No
Convulsion or epilepsy?	Yes No	Cancer or tumors?	Yes No	Diabetes?	Yes No
Heart Condition?	Yes No	Headaches?	Yes No	Allergies to medication?	Yes No
High Blood Pressure?	Yes No	Fainting Spells?	Yes No		

List any allergies or other medical conditions of which we need to be aware _____

For routine first aid needs, list any O-T-C medications that the participant may NOT take _____

I am the parent or legal guardian for the above-named participant, and give my permission for him/her to attend the event, sponsored by Kiwanis International. I hereby certify that the information provided above is correct.

In the case of medical emergency, I understand that every effort will be made to contact the emergency contacts listed above. In the event those persons cannot be reached or time does not permit, I hereby give permission to a licensed physician *or other licensed medical provider,* to provide proper treatment, including but not limited to hospitalization, injection, anesthesia and/or surgery, for the above-named participant. On behalf of myself and my ward/minor, I/we hereby **RELEASE, WAIVE AND FOREVER DISCHARGE** Kiwanis International and its officers, directors, employees, parents and subsidiaries, agents, from any and all claims, liabilities, causes of actions, damages, demands, judgments, executions, liens and costs whatsoever, in law or equity, including, without limitation, liability for death or bodily injuries to any person or damage to any property resulting from any (i) claims made against medical providers of emergency services under this authorization, or (ii) against Kiwanis International for obtaining medical emergency services for said participant pursuant to this authorization.

Parent or guardian _____ Signature _____ Date _____
(Required if under the age of 18)