FORM B – Archdiocese of Cincinnati – DUE May 23, 2008

WYD – Sidney, OH	MEDICAL RELEASE FORM ONE FORM PER ADULT & YOUTH

** Each participant must keep a copy of this form inside their name badge at all times! **

PLEASE TYPE OR PRINT CLEARLY

Name of Parish/School/Organization: ______________________________

City of Parish/School/Organization: ______________________________

Name of Participant: ______________________________

Address of Participant: ______________________________

City: ____________________ State: ____________ Zip: __________

Phone #: ( ) ______________ Birth Date: ___/___/___ Grade: ___ ☐ Male ☐ Female

List only the Parent/Guardian(s) with whom participant resides (Adults skip the guardian info.):

Mother/Guardian Name: ______________ Father/Guardian Name: ______________

Daytime Phone #: ( ) ______________ Evening Phone #: ( ) ______________

Other Emergency Contact Name: ______________ Phone #: ( ) ______________

Health Insurance Co.: ______________ Policy #: ______________

Physician: ______________ Phone #: ( ) ______________

Medications currently taken (prescription and non-prescription) and include dosage: ______________

____

Allergies: ______________________________

Special Needs/Concerns: ☐ Wheelchair Access ☐ Hearing Impaired ☐ Visually Impaired

☐ Mobility Impaired ☐ Other special needs/concerns: ______________

Can this person be given the following medications while attending WYD-Sidney?

Aspirin? ☐ Yes ☐ No Acetaminophen (i.e. Tylenol)? ☐ Yes ☐ No Ibuprofen? ☐ Yes ☐ No

YOUTH: *I hereby certify that the above information is correct and give permission for my child to be transported in privately owned vehicles for medical emergencies only, and for the release of medical records to an attending health worker in case of illness. I understand that every effort will be made to contact the parent/guardian. If one cannot be contacted, I hereby give permission for a qualified physician to secure proper treatment for my child.*

______________________ ______________________

Print Parent/Guardian Name Parent/Guardian Signature Date

ADULTS: *I hereby certify that the above information is correct and give permission to be transported in privately owned vehicles for medical emergencies only, and for the release of medical records to an attending health worker in case of illness. I hereby give permission for a qualified physician to secure proper treatment for me.*

______________________ ______________________

Name Signature Date