PARTICIPANT MEDICAL INFORMATION AND TREATMENT AUTHORIZATION

Student Name _____ **Social Security #** _____ **Date of Birth** _____ **Sex** _____

Address _____ City _____ State _____ ZIP Code _____

Mother's Name_____ Father's Name_____

Custodial Parent ❒ Yes ❒No Custodial Parent ❒ Yes ❒No

Daytime Phone #_____ Daytime Phone #_____

Evening Phone # _____ Evening Phone # _____

Person to be notified in case of emergency, if parents cannot be contacted:

Name _____ Relationship _____ Phone # _____

Known medical conditions_____

Known allergies_____

Are you medically restricted from participation in physical/recreational activities? Y N

Reason? _____

Current medications_____ **Medicaid #** _____

(if applicable)

Health Insurance_____

Company **Identification #** **Group #**

I hereby authorize any senior staff member of the APPLE Project to take the following actions regarding medical care for my child/ward at any time when said child is enrolled in the APPLE Project or is participating in any APPLE Project activity:

1) APPLE Project staff members may provide first aid for minor injuries and illnesses, including providing over-the-counter medications for headache, fever, stomach ache, etc.
2) APPLE Project staff members are authorized to select and employ a qualified physician and to use local hospitals and clinics for the treatment of illness or accident.
3) APPLE Project staff members are authorized to render such information as is required in order to obtain medical examination and treatment.
4) I understand that (A) physicians and hospitals are reluctant and sometimes unwilling to treat patients without authorization from parents/guardians, and (B) the APPLE Project will permit only routine and emergency procedures. I understand that major or prolonged treatment will be undertaken only with my specific permission, except when such permission is impossible to obtain within the limitations of time or other conditions.
5) I understand that in the event of accident or illness, all action of the APPLE Project's regular and medical staff or agents will be guided by the best interest of my child.
6) I understand that I, my heirs, executors, and administrators forever release the Director of the APPLE Project and all designated senior staff from all claims, damages, actions, or course of actions which may occur due to any decisions which they make with respect to the medical care and treatment of my child.
7) I further release Lyon College and its employees from any and all claims and liabilities of any type for injury to or death of any person or persons which may result from participation in APPLE project and its activities.

I, _____, certify that I am the parent or guardian of_____, and that
(Parent Name-please print) (Student Name-please print)
my signature below indicates my agreement with the above statements.

_____ _____

Parent/ Guardian Signature (*blue/black ink*) **Date**