FORM D – Archdiocese of Detroit

NFCYM NCYC	**MEDICAL RELEASE** FORM ***ONE FORM PER ADULT & YOUTH ***

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

PLEASE TYPE OR PRINT CLEARLY

First Name: _____ Last Name: _____

Parish:_____Birth Date (mm/dd/yy)____/_____/_____ Sex ☐ Male ☐ Female

Health Insurance Co.: _____ Policy #: _____

Group #: _____ Contract #: _____

Physician: _____ Phone #: ( ) _____

Medications *(prescription and non-prescription-including dosage)* ***and additional medical information and recommended course of action*** *(dietary restrictions, etc.)*: _____

_____

Allergies: _____

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

☐ Mobility Impaired ☐Other special needs/concerns: _____

If this person requires dispensing of medications while attending NCYC, please see the Release for Dispensing of Medication form.

In case of emergency, I consent to any X-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the adult/minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. This authority is granted only after every effort has been made to reach the parent/guardian.

The undersigned shall be liable and agree(s) to pay all cost and expenses incurred in connection with such medical and dental services rendered to the above-mentioned participant pursuant to the authorization.

Should it be necessary to return home due to medical reasons or infraction of the rules, the undersigned shall assume all transportation costs.

I hereby give permission to ride in any vehicle designated by the adult in charge whose care the participant has been entrusted while attending and participating in activities sponsored by the **Archdiocese of Detroit and NFCYM.**

I hereby certify that the above information is correct and consent 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.

_____ _____

Print Parent/Guardian Name Parent/Guardian Signature Date

OR

_____ _____

Print Adult Participation Name Adult Participant Signature Date

Group Leaders please keep a copy of this and all forms.