MEDICAL AUTHORIZATION

COMPLETE BOTH SIDES!

Name of Children: Last, First

Student 1 Name: ____________________, ____________________

Student 2 Name: ____________________, ____________________

Student 3 Name: ____________________, ____________________

❑ **CHECK IF ENROLLING MORE THAN 3 STUDENTS** *(and using 2 Registration Forms)*

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, Vaseline, Ibuprofen, Naproxen and/or Tylenol.

NOTES & 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: __________

COMPLETE BOTH PAGES!

MEDICAL AUTHORIZATION
STUDENT INFORMATION

Please Print Legibly!

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

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 or other medical needs should bring their medication in the original pharmacy container to first aid person and check it in with the first aid person or coach each time. Tell us anything else we should know about your child (shy, ADHD, does not play easily with others)? Additional information may be required for asthmatic children. Please see the first aid person to be sure.

STUDENT INFORMATION: **NAME = LAST NAME, "Name go by"** ***(Only include students enrolling in HCYA activities)***

Student 1 Name ______________________ , ______________________ SEX: ____ Birthdate: ______________ Age: ____
Last First

Medical Info (note any allergies): ____

Other Info: ____

Student 2 Name ______________________ , ______________________ SEX: ____ Birthdate: ______________ Age: ____

Medical Info (note any allergies): ____

Other Info: ____

Student 3 Name ______________________ , ______________________ SEX: ____ Birthdate: ______________ Age: ____

Medical Info (note any allergies): ____

Other Info: ____

FAMILY INFORMATION: Notify us of any changes during the year

Father's Name ____________________ , ____________________ Employer/Job ______________________
Last First

Mother's Name ____________________ , ____________________ Employer/Job ______________________

Address: ______________________________ City ____________________ State _____ Zip __________

Family Home Phone ____________________

Father Email ______________________________ Mother Email ______________________________

Father Work Phone ______________________ Mother Work Phone ______________________

Father Cell Phone ______________________ Mother Cell Phone ______________________

INSURANCE COMPANY NAME (Insurance not required to participate): ______________________________

Policy Holder Name: ______________________________ SS# ____________________

Employer Of Policy Holder: ____

Policy No: ____

PHYSICIANS NAME ____

Address ______________________________ City ____________________ State _____ Zip __________

Physician's Phone ____________________ Physician's Hospital ______________________________

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

Emergency Contact Name: ____

Emrg Home Phone ________________ Emrg Work Phone ________________ Emrg Cell Phone ________________

COMPLETE BOTH PAGES!