YRUU MEDICAL RELEASE FORM 2019-2020

Youth's Name _____

Address _____

City/State/Zip _____

Phone Number(_____)_____ Date of Birth _____/_____/_____

Parent or Guardian _____

Address (if different)_____

City/State/Zip_____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Parent or Guardian _____

Address (if different)_____

City/State/Zip_____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Contact Persons - in case of emergency or illness and parents/guardians can't be reached, the following people may be contacted:

1) Name_____ Phone # (_____)_____ Relationship_____

2) Name_____ Phone # (_____)_____ Relationship_____

Name of Health Insurance Provider _____

Policy number _____

Physician's name _____

Effective Date_____/_____/_____

Phone Number (_____)_____

Youth Medical History

Drug allergies: _____

Other allergies: _____

Medications used regularly or as needed: _____

_____

Date of last tetanus shot: _____/_____/_____

I give permission for (name of youth)_____ to receive any needed medical care and treatment required in my absence. I understand I will be responsible for the payment of any care expenses not covered by my insurance.

Signature of parent/guardian _____ **Date**_____