

MEDICAL AUTHORIZATION

As the parent/legal guardian, I give full authorization to the Clackamas Family YMCA staff or designated adult leaders to secure medical care or treatment for the youth named below. This treatment may include assistance from the nearest physician, dentist, medical clinic, hospital, trained nurse or EMT in the event of illness or injury that requires immediate attention, as determined by the program staff or their designee. In the event that I cannot be contacted, and an emergency has occurred, I give permission to the treating medical institution and/or medical providers to hospitalize and administer the appropriate treatment deemed medically necessary.

I further agree that no YMCA of Columbia-Willamette employees, agents, or volunteers will be held responsible for injuries or damages arising from the provision of any such emergency medical treatment. I understand that as a parent/legal guardian, I will be responsible for the cost of any service or treatment provided. The YMCA will not cover costs incurred.

The undersigned understand and agree that the YMCA shall not be legally or financially liable for any claim arising from any medical care provided pursuant to this authorization. The undersigned hereby agree to indemnify to save and hold harmless the YMCA from any claim made by or on behalf of said minor arising out of any medical care provided pursuant to this authorization

This authorization shall remain effective until he/she completes their activities in this program unless sooner revoked in writing. I have read this document, I understand its contents, and I agree to its terms.

Youth Name: _____
(Please Print)

Date: _____

Parent/Guardian Signature: _____

Parent/Guardian Name: _____
(Please Print)

Phone (Day) _____

Phone (Evening) _____

MEDICAL HISTORY

This information is confidential and will be used only in case of emergency.

Name of Physician _____

Telephone _____

Address _____

Currently under physician care? YES NO If yes, what condition? _____

Currently taking medication? YES NO

Name of Medication:

Dosage:

Time taken:

Any allergies, food, special dietary restrictions, drug reactions? YES NO

Are there any conditions or special needs that staff should be aware of?