

**PACIFIC YEARLY MEETING
MEDICAL HISTORY & INFORMATION**

Please fill out this form in ink, one form per youth. Use the back of this page if needed. This and the permission form are both needed for your youth to participate.

CHILD'S NAME: _____

BIRTHDATE _____

Medications, dosage and schedule

Is your child/ teen currently under treatment for depression, anxiety, mental health, or physical conditions?

other information

MEDICAL HISTORY/CONCERNS:

Date of last tetanus shot _____

Allergies

Child's doctor _____

Telephone _____

Insurance company

Policy holder's name _____

Policy # _____

If an HMO, please give name and telephone #

Child/Teen's social security number _____ - _____ - _____

PARENTS' OR GUARDIAN'S EMERGENCY NUMBERS DURING EVENT:

Mother / legal guardian's name _____ Phone/Cell

Father / legal guardian's name _____

Phone/Cell _____

IN THE EVENT THAT PARENT / LEGAL GUARDIAN CANNOT BE CONTACTED,
CALL:

Name _____ Relationship _____

Telephone _____

PLEASE NOTE: The child needs to bring his/her insurance card (or a photocopy) to the event

Date completed _____

By _____ (print name)

Signature _____

Medical Release form and Field Trip Permission for minor (age 17 & under)
Pacific Yearly Meeting of the Religious Society of Friends (PYM)

**AUTHORIZATION FOR THIRD PARTY CONSENT TO MEDICAL TREATMENT OF MINOR LACKING
CAPACITY TO CONSENT AND FIELD TRIP PERMISSION FOR MINOR**

I/We the undersigned parent(s) having legal custody/guardianship of _____ (age _____ yrs) , a minor, do hereby authorize any personnel or any staff person(s) of Pacific Yearly Meeting of the Religious Society of Friends as agent(s) for the undersigned to consent to any X-ray examination, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the provision of the Medical Practice Act on the on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but it is given to provide authority to the aforesaid agent(s) to give specific diagnosis, treatment or hospital care which a physician, meeting the requirements of this authorization, may, in the exercise of her/his best judgement deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

I/We hereby authorize any hospital which has provided treatment to the above-named minor pursuant to the provisions of the Section 25.8 of the Civil Code of California to surrender physical custody of such minor to my/our above named agent(s) upon completion of the treatment. This authorization is given pursuant to Section 1283 of the health and Safety Code of California.

In addition, the above named minor has my /our permission to participate in the program at Pacific Yearly Meeting organized for his/her age group. This includes permission to go on field trips (including swimming). (It is PYM's policy that all passengers are seat-belted and all drivers have appropriate automobile insurance.)

These authorizations shall remain effective through Saturday, August1, 2009, unless sooner revoked in writing delivered to said agent(s).

The undersigned agree to hold Pacific Yearly Meeting of the Religious Society of Friends and its officers, agents, teachers and other personnel harmless of claim by the undersigned arising out of any medical treatment given by or attempted in connection with any medical emergency.

_____ Date _____ (printed name) _____ (signature)
Parent/Legal Guardian/Person Having Legal Custody (circle relationship)

_____ (printed name) _____ (signature)
Parent/Legal Guardian/Person Having Legal Custody (circle relationship)

Known allergies _____

Swimming ability _____

Accident or Health Insurance Company _____

Policy Number _____ Medical Record Number _____

Regular Physician _____ Phone () _____

Name of person in whose name insurance is carried _____

Circle coverage: Hospital Surgical accidents general