**Participant Information**

|  |  |
| --- | --- |
| Name |  |
| Gender |  |  | Grade |  |
| Date of Birth |  |  | Age |  |

**Parent/Guardian Information**

|  |  |
| --- | --- |
| Name(s) |  |
| Phone Number(s) |  |
| Email Address(es) |  |

**Emergency Contact Information**

|  |  |
| --- | --- |
| Primary Emergency Contact Name |  |
| Primary Emergency Contact Phone Number |  |
| Secondary Emergency Contact Name |  |
| Secondary Emergency Contact Phone Number |  |

**Physician:**

|  |  |
| --- | --- |
| Physician Name |  |
| Physician Phone Number |  |
| Physician’s Address |  |

**Medications**

Any prescriptions that your minor child will be taking during this event must be dropped off by the Diocesan Chaperones to the Event Chaperones.

The following medications will be available to your minor child to take with your permission.

*I/we (the parent/guardian(s) of the minor child named above) give permission for the minor child named above to take:*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Cough drops |  | Tylenol |
|  | Motrin  |  | Benadryl |
|  | Mylanta |  | Ibuprofen |

(PLEASE CHECK ALL THAT APPLY)

**Medical Information**

|  |
| --- |
| Medical Insurance Company & Policy Number |
|  |
| Known allergies & medical conditions |
|  |
| Current medications |
|  |
| Operations or major illness (specify issue & date) |
|  |
| Please indicate special needs for mobility/accessibility |
|  |
| Please indicate any dietary restrictions: |
|  |
| Date of most recent tetanus booster shot (within past five years) |
|  |
| Additional medical information/comments |
|  |

**Medical Release**

*In the event I/we (the parent/guardian(s) of the minor child named above) cannot be reached during a medical emergency or following any accident: I/we authorize the Episcopal Diocese of Central New York to act on my/our behalf in carrying out the best treatment possible in consultation with my child's attending board certified and licensed physician or surgeon at an accredited hospital. I assume all responsibility for costs if medical care is provided to my child.*

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |