DEMOLAY INTERNATIONAL

MEDICAL HISTORY and RELEASE FORM

IDENTIFICATION of PARTICIPANT

(Required for all participants under 21 years of age or younger)

NAME _____ AGE _____

ADDRESS _____ ACTIVE DEMOLAY ( )

CITY _____ VISITOR ( )

STATE _____ ZIP_____ GENDER _____

I hereby promise to conduct myself in a responsible manner and abide by DeMolay rules and regulations and the rules and regulations of this DeMolay event. I will be subject to being dismissed from the event and sent home at my own expense if I do not abide by this promise. I shall indemnify and hold DeMolay International, The International Supreme Council of the Order of DeMolay, and all Affiliated Organizations harmless from and against all penalties, losses, costs, damages, suits, judgments, claims, demands, expenses and liabilities of any kind or nature whatsoever, arising directly or indirectly out of or in connections with my attendance at the DeMolay event.

_____ _____ _____ _____

(Participant's signature) *(Date)* *(Parent/Legal Guardian signature)* *(Date)*

CONSENT and RELEASE

I, the undersigned Parent/Legal Guardian of the above identified participant, do hereby give my consent and permission for them to participate in all activities and events conducted by _____. I agree to release and hold harmless members, advisors, and officers of DeMolay International, from all claims or cause of actions, which the undersigned has or may have. In the event of injury or illness to the above named participant, I hereby authorize any Advisor in attendance to secure, and any healthcare provider in attendance to provide such emergency treatment as may be deemed necessary by those present including but not limited to hospitalization, medication administration, diagnostic radiology and procedures, surgery, and blood transfusions. I understand reasonable efforts will be made to contact me prior to medical treatments.

_____ _____

(Parent/Legal Guardian signature) *(Date)*

I may be reached at the following numbers during the above event:

CELL ( ) - _____ HOME ( ) - _____ OTHER ( ) - _____

EMERGENCY CONTACT: _____ TELEPHONE NUMBER:_____

MEDICAL INSURANCE INFORMATION:

INSURANCE CARRIER: _____ POLICY HOLDER: _____

POLICY/GROUP # _____

TELEPHONE NUMBER for EMERGENCY INSURANCE AUTHORIZATION: ( ) -_____

MEDICAL HISTORY of PARTICIPANT

Is participant currently under care for any illness or injury? ( ) YES ( ) NO

Explain:

_____

_____

Has participant had any surgeries or significant injuries in the past 12 months ( ) YES ( ) NO

Explain:

_____

_____

Does participant have any food, drug, or contact allergies? ( ) YES ( ) NO

List any, and describe reaction (example – hives)

_____

_____

Will the participant have any prescribed or over-the counter medications with them?

( ) YES ( ) NO List any, and when the medication is to be taken:

_____ _____

_____ _____

Does participant have any disability or physical limitations that may affect participation in activities or require special arrangements? (example – requires handicapped-accessible bathroom)

_____

_____

Please list any special dietary needs or restrictions (medical/religious – example: gluten free or no pork)

_____

_____

List any other condition or concerns we should be aware of:

_____

_____