



Of Greater Fort Lauderdale, Inc.

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MEDICAL INFORMATION AND RELEASE FORM

To be completed by the child's Parent/ Legal Guardian

(Please Print Clearly)

Name of Child _____ Boy _____ Girl _____

Address _____ Zip _____

Parent of Guardian Name _____ Phone _____

Address _____ Zip _____

Child's Date of Birth _____

Emergency Contact and Relationship to Child (not a parent) _____ Phone _____

Insurance Yes _____ No _____ If yes, Name of Company _____

Group Number _____ Identification Number _____

Family Doctor _____ Phone _____

Address _____

Does student have any special medical problems? Yes _____ No _____

If yes, please explain _____

Is student taking any medications? (Include non-prescription drugs) Yes _____ No _____

If yes, please specify _____

Is student allergic to any drugs? Yes _____ No _____

If yes, please specify _____

Is student allergic to insect bites? Yes _____ No _____

If yes, does student have an insect bite kit for emergencies? Yes _____ No _____

Date of child's last Tetanus shot _____

Does student take any medications which require adult supervision? Yes _____ No _____

If yes, please attach a letter from his/her doctor containing the instructions and permission to administer the medication.

I am giving employees, chaperones and affiliates of *the 100 Black Men of Greater Fort Lauderdale, Inc.* permission to administer medication to my child per the following:

Prescribed Medication

Name of Medication: _____ Dose (how much): _____

Frequency (how often): _____ Time: _____

Date Prescribed: _____ Duration: Start Date _____ End Date _____

Route (circle one) Mouth Ear Eye Nose Skin

Reason for Medication: _____

Prescription Number: _____ Prescribed By: _____

Special Instructions: _____

Please allow my child to self-administer this medication

Name of Medication: _____ Dose (how much): _____

Frequency (how often): _____ Time: _____

Date Prescribed: _____ Duration: Start Date _____ End Date _____

Route (circle one) Mouth Ear Eye Nose Skin

Reason for Medication: _____

Prescription Number: _____ Prescribed By: _____

Special Instructions: _____

Please allow my child to self-administer this medication

Non-Prescribed Medication

Tylenol Aspirin Sunscreen Bug Spray
Neosporin/Cortisone Cough Drop Antiseptics RID

Other _____

Parent/Guardian's Signature

Date

Authorization for Medication Administration

I hereby give permission to the **100 Black Men of Greater Fort Lauderdale, Inc.** to authorize emergency medical care for my minor child,

_____, and I hereby represent that I am the parent or legal guardian with the legal right to provide such authority. This authorization shall include and not be limited by specific permission to the physician to hospitalize, secure treatment for and to order injections, anesthesia or survey for said minor child, according to the advice of medical personnel. I understand that this authorization shall not obligate the **100 Black Men of Greater Fort Lauderdale, Inc.** in any way to provide medical care to my minor and that I will remain solely liable and responsible for any medical services provided to such minor child.

I hereby release, waive and discharge any and all claims against the **100 Black Men of Greater Fort Lauderdale, Inc.** including its officers, directors, members, employees, contractors, agents, sponsors and volunteers, in connection with any injury to my minor child and any medical attention provided to my minor child, in connection with the programs of **100 Black Men of Greater Fort Lauderdale, Inc.** and this authorization, including but not limited to any transportation of my minor child and involvement of my minor child in connection with events of the **100 Black Men of Greater Fort Lauderdale, Inc.**

This release and authorization shall survive the programs in which my minor child may be involved with the **100 Black Men of Greater Fort Lauderdale, Inc.** and shall be an absolute bar against any action to recover damages for injuries to my minor child. The authorization also authorizes the **100 Black Men of Greater Fort Lauderdale, Inc.** and medical personnel, as appropriate, to have access to available and necessary records regarding my minor child, in accordance with applicable laws.

Parent/Guardian's Signature

Date