



DELAWARE DeMOLAY Medical History Information Release and Consent Form 2011

In order to provide for a safe and meaningful experience for all our participants, Delaware DeMolay requires all program participants to fill out the following forms: Delaware DeMolay Medical Information, and Delaware DeMolay Medical History and release.

The following packet consists of: Delaware DeMolay Medication Policy, Delaware DeMolay Medication Information, and Delaware DeMolay Medical History and release.

Delaware DeMolay Medication Policy

This form explains our policy pertaining to your child, and his medical needs.

Delaware DeMolay Medication Information

This form is to be carried by the advisor accompanying your child. The information lists the medications, and dosages your child is allowed to take, if needed.

Delaware DeMolay Medical History and release.

Medical History: Leave no blanks. If an item does not apply, write N/A. Attach additional sheets if needed.

Because of the hipaa rules, and information act, this form must be filled out and signed by the parent/guardian of the particular child. Once the form is filled out, **COMPLETELY**, it will be folded, put into the accompanying envelope, and sealed by the parent/guardian. The parent/guardian will then sign over the sealed part, or flap of the envelope. Information will only be accessed in the event of an emergency.

All forms shall be returned to the Chapter Advisor.



DELAWARE DeMOLAY Medical History and Release 2011

In order to provide for a safe and meaningful experience for all our participants, Delaware DeMolay requires all programs participants to submit this medical history and release, to be completed and signed by a parent/guardian. If this form is on file for your child's participation in another event, you may not need to submit a new one. However, a new form is required for every calendar year, or any significant change in health status. Youth may not be permitted to participate in an event without a current release on-site. Please be as detailed as possible. Information will be treated as confidential.

Youth' Full Name _____
(Last) (First) (Middle)

Youth's E-mail _____

Gender _____ Birthday _____ Age _____ SSN _____ Birthplace _____

Parent or Guardian Name _____

Does the youth live with you? _____

Home Address _____

Home Phone _____ Business Phone _____ Cell Phone _____

E-mail _____

If not available in an emergency, notify:

1. Name _____ Phone _____ Cell Phone. _____

Street Address _____

City _____ State _____ Zip _____ Relationship to Child _____

2. Name _____ Phone _____ Cell Phone. _____

Street Address _____

City _____ State _____ Zip _____ Relationship to Child _____

Medical History: Leave no blanks. If an item does not apply, write N/A. Attach additional sheets if needed.

State the name of this child's family physician and of any other physician who should be consulted in the event of emergency or medical problem.

Name of primary Care Physician _____ Phone _____

Name of other Physician _____ Phone _____

Please indicate the primary medical insurance for this child:

Please photocopy the front and back of you child's insurance card and place it with this form.

Name of Insurance Co. _____

Address _____

Policy No. of Insurance Policy _____

Name of Policy Holder _____

Policy Holder's Social Security Number _____

Policy Holder's Date of Birth _____

Phone No. of Insurance Co. _____

Does this child have any of the following allergies:

Penicillin yes / no

Other Drugs yes /no

Insect Stings yes /no

Ivy Poisoning, etc. yes /no

Hay Fever yes /no

Peanuts yes / no

Other: _____

Indicate the date of this child's last tetanus shot _____

State the name of this child's Dentist (and orthodontist if applicable)

Name of child's Dentist _____ Phone _____

Name of child's Orthodontist _____ Phone _____

I/ We understand that many youth activities may involve travel. In the event of an accident or injury to my child, while on a DeMolay activities or otherwise, I will not hold the Delaware DeMolay or adult sponsors responsible. I understand that The Delaware DeMolay does not carry medical and hospitalization insurance coverage.

I further understand that, in the event my child requires medical or dental treatment while engaged in an activity with The Delaware DeMolay, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the Delaware DeMolay, and sponsor or any adult sponsor acting on behalf of the Delaware DeMolay with respect to the activity, as agent for me, to consent to any X-ray examination; injections; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my child's medical allergies, medications being taken, medical problems and other pertinent information. My child has permission to participate in all prescribed activities except as noted by me.

Signature _____ Date _____
(Parent or Guardian)



DELAWARE DeMOLAY Medication Information 2011

In order to provide for the safety of our participants, Delaware DeMolay requires that our adult leaders supervise your child's medication during an event. All medication brought to events, prescription or not, must be left in adult care for the duration of the event. Please provide complete dosage/schedule information. No medications are to be left in participant's possession, except those that are for emergency use (for example, a rescue inhaler). Our complete medication policy is on the back of this form.

Youth' Full Name _____
(Last) (First) (Middle)

List medications participant takes currently or regularly _____

Will your child be bringing any medication to the event? (circle one) yes / no If yes, be sure to complete, **Medication information and schedule** section.

Over-the-counter Medication: I give my permission for my child to have the following over-the counter medication, or their generic equivalent, as needed during the event. (We will not give excess over-the counter medication contrary to the express written directions on the packaging). Initial those you approve.

For headaches/pain

- _____ Tylenol (Acetaminophen)
- _____ Advil (ibuprofen)
- _____ Aleve (Naproxen sodium)
- _____ Other (specify) _____

For upset stomach, diarrhea, etc.

- _____ Pepto-Bismol (Bismuth liquid or tablets)
- _____ Mylanta/milk of Magnesia (Mg/Al based antacids)
- _____ Tums/Roloids (Calcium based antacids)
- _____ Imodium (Loperamide)
- _____ Other (specify) _____

For allergic reaction (hay fever, insect sting, etc.)

- _____ Benadryl (Diphenhydramine)
- _____ Sudafed (Pseudo ephedrine HCl)
- _____ Hydrocortisone cream
- _____ Calamine lotion
- _____ Other (specify) _____

For sore throat/cough

- _____ Cough drops/lozenges
- _____ Chloraseptic spray (Phenol)
- _____ Other (specify) _____

May we provide your child with sunscreen? Yes / no

Other (specify) _____

Does this child have any of the following allergies:

- Penicillin yes / no
- Other Drugs yes /no
- Insect Stings yes /no
- Ivy Poisoning, etc. yes /no
- Hay Fever yes /no
- Peanuts yes / no

Other: _____

We may also dispense routine first aid items such as non-prescription antibiotic creams, lotions, antiseptics, artificial tears, and so on. Please indicate here if there are any your child may **NOT** have: _____

Does participant have any food, drug, or contact allergies? List, with reactions where applicable _____

Does participant have any disability or physical limitations which might affect participation in conference activities, or require special arrangements? _____

Does participant have a **medical** need for a ground floor room, or handicapped-accessible bathroom? Yes / no

Does this child have any medical or health problems, and has this child had any chronic or recurring illness or illnesses, which would have an effect on the child's participation in the youth program? No _____ Yes _____

If yes, describe the illness or problem.

MEDICATION INFORMATION AND SCHEDULES:

For the safety and health of all our participants, the Delaware DeMolay policy requires that all medication [prescription or over-the-counter] be kept in possession of adult leaders or program staff for the duration of the program. Medication will be dispensed to your child at your specified dosages and times

We need to know if your child takes each medication as needed or on a routine schedule. If you check "as needed" for a given medication, we will only dispense the medication when your child asks for it. If you check "as scheduled" for a medication, we will remind your child each time a dose is scheduled. Please check only one column for each of the medications.

All medications should be sent in the original containers. We prefer you send only the number of pills needed for the duration of the program. If the *instructions differ* from the label on the medication [for example: if the Dr. has instructed you to change the dosage, but a new prescription has not been filled] *please explain below*.

Variations, or other instructions _____

Medication	Dose	Time(s)	Special Instruction	As needed	As scheduled

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I further understand that, in the event my child requires medical or dental treatment while engaged in an activity with The Delaware DeMolay, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the Delaware DeMolay, and sponsor or any adult sponsor acting on behalf of the Delaware DeMolay with respect to the activity, as agent for me, to consent to any X-ray examination; injections; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my child's medical allergies, medications being taken, medical problems and other pertinent information. My child has permission to participate in all prescribed activities except as noted by me.

Your signature below is your authorization to dispense medication according to your instructions written above.

I have read the Delaware DeMolay Medications Policy. And I hereby authorize Delaware DeMolay adult leaders or program staff to dispense my child's medication according to the schedule above.

Parent or Guardian's signature: _____ Date _____