FREEDOMS FOUNDATION AT VALLEY FORGE
2024
STUDENT MEDICAL INFORMATION FORM

This form consists of FOUR sections. In order to be admitted to the Rotary District 7540 RYLA, each section needs to be completed with the required signatures and be received by the RYLA Organizing Committee.

NAME OF PARTICIPANT _____

I. PARENT'S WAIVER

We (I) hereby give permission for the above-named student to attend the **RYLA conference from February 2, 2024 to February 4, 2024** to be conducted at Freedoms Foundation at Valley Forge. We (I) understand participation in this conference is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. We (I) hereby release and discharge the Rotary International, Rotary District 7450 Inc. and all of its affiliated member Rotary and Rotaract Clubs, Freedoms Foundation at Valley Forge, and all officers, agents, instructors, volunteers, employees, and related parties associated with this conference from any and all claims, demands, suits, actions or causes of action which we (I) may or shall have reason of any illness, injury or accident incurred or suffered by the above-named participant at this conference and in the course of travel by any means to and from and while on the premises of the Freedoms Foundation at Valley Forge, no matter how caused or occasioned.

Names of Parents or Guardians *(circle one)* **(Please print)**

_____

Signature of Parents/Guardians

_____ **Date** _____

Telephone: Home _____ **Office** _____

II. INSURANCE

Freedoms Foundation does not carry medical insurance to cover participants. All participating students are required to be covered by personal or family insurance.

We (I) hereby certify, under penalty of perjury, that the above-named student is covered

Names of Parents or Guardians (please print)

Signature of Parents/Guardians

Date

Insurance Company

Expiration Date of Insurance

Please list emergency number(s) **other than those above** at which parent, guardian, or another relative may be reached during the conference.

(Please print and relationship to student)

Name	**Name**
Relationship	**Relationship**
Telephone	**Telephone**

III. PARENTS CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event that our (my) child _____ becomes ill or sustains an injury while under the supervision of the Freedoms Foundation staff, we (I) hereby give permission to administer first aid for our (my) child's relief. If it is not practical to return our (my) child to us (me), or to receive our (my) instructions for his/her care, consent is given to any licensed physician and/or surgeon to whom our (my) child is taken for treatment, to administer such treatment, drugs, and medicines and to perform such surgical procedures as the licensed physician and/or surgeon shall think the existing emergency requires for the relief of pain, and to preserve our (my) child's life and health. We (I) understand and agree that while the Freedoms Foundation staff may seek medical treatment for our (my) child, we (I) hereby release and discharge the Freedoms Foundation, its officers, agents, instructors and employees, for any and all demands, suits, actions or causes of actions that we (I) may or shall have by reason of arranging for such medical treatments or from failure to seek such medical treatments. We (I) further agree to be completely responsible for any bills that occur in providing medical care.

Name of Parents or Guardian (please print)

_____

Signature of Parents/Guardians

_____ **Date** _____

IV. STUDENTS MEDICAL HISTORY

Participant Name:		**Birth Date:**			
Address:					
City:		**State:**		**Zip Code:**	

Date of most recent exam:		**Weight:**		**Height:**	
Date of most recent tetanus toxoid (aka DTP) immunization:					

Doctor's Name:					
Doctor's Address:					
City:		**State:**		**Zip Code:**	
Doctor's Phone:					

HEALTH HISTORY

Please provide any information about a student's health history that may impact their participation in the program. This may include health concerns, food and medication allergies (see below), and/or current medications (see below). Attach additional pages if necessary.

Allergies (Hay fever, insect stings, etc.)	
Food allergies:	
Medication allergies:	
Current Medications:	

***** Please bring Epi Pen if applicable.**

HEALTH INSURANCE CARD

***A photocopy of the student's health insurance card – front and back - is required with this Medical Form.**

Photocopy this page with

FRONT SIDE

of Health Insurance card showing here

Then Photocopy this page with

BACK SIDE

of Health Insurance card showing here