Medical Authorization / Release Form

Formulario de Autorización / Liberación Médica

Student's Name_____

DOB_____ Age_____ Male____ Female____

Address_____ City_____ State____ ZIP_____

Phone Number_____ Religious Preference_____

Health/Accident Insurance Company_____ Policy No._____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD
IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE"

In case of emergency, notify:

Name_____ Relationship_____

Address_____ City_____ State____ ZIP_____

Home Phone_____ Cell Phone_____

Name_____ Relationship_____

Address_____ City_____ State____ ZIP_____

Home Phone_____ Cell Phone_____

Name_____ Relationship_____

Address_____ City_____ State____ ZIP_____

Home Phone_____ Cell Phone_____

MEDICAL HISTORY / HISTORIA MEDICA

Are you now, or have you ever been treated for any of the following?
¿Está usted ahora, o le han tratado alguna vez para cualquiera de los siguientes?

Yes	No	Condition	Date/Explain
		Asthma	
		Diabetes	
		Hypertension (high blood pressure)	
		Heart Disease (i.e. CHF, CAD, MI)	
		Stroke/TIA	
		COPD	
		Ear/Sinus problems	
		Muscular/skeletal condition	
		Menstrual problems	
		Psychiatric/psychological and emotional difficulties	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures	
		Sleep disorders (i.e. sleep apnea)	
		GI problems (i.e. abdominal. digestive)	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to: _____
Medication_____
Food, Plants or Insect bites_____
_____

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form). Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication_____
Strength_____Frequency_____
Reasons for medication_____
_____
Approximate date started_____
Temporary_____ Permanent_____

Medication_____
Strength_____Frequency_____
Reasons for medication_____
_____
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Temporary_____ Permanent_____

Medication_____
Strength_____Frequency_____
Reasons for medication_____
_____
Approximate date started_____
Temporary_____ Permanent_____

PRESCRIPTIONS: The taking of prescription medications is the responsibility of the individual taking the medication and/or that of the individual's parent or guardian.

PRESCRIPCIONES: La toma de medicamentos recetados es responsabilidad del individuo que toma el medicamento y / o el del padre o GA del individuo.

NOTE: Be sure to always bring medications in the appropriate containers and make sure that they are NOT expired, including inhalers and EpiPens.

NOTA: Asegúrese de traer siempre los medicamentos en los recipientes apropiados y asegúrese de que NO han expirado, incluyendo inhaladores y EpiPens.

Informed Consent of Medical Authorization

I approve the sharing of the information on this form with the Salinas Valley Dream Academy team members, volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of activities.

In case of emergency involving my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. **In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult team leader or Academy Director in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child**. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardians, and/or determination of the participant's ability to continue in the program activities.

Without restrictions.

With special consideration or restrictions (list), if any: _____

Consentimiento Informado de Autorización Médica

Yo apruebo compartir la información en este formulario con los miembros del equipo de Salinas Valley Dream Academy, voluntarios y profesionales que necesitan saber de situaciones médicas que podrían requerir consideración especial para la conducción segura de actividades.

En caso de una emergencia que involucre a mi hijo/a, entiendo que se hará todo lo posible para contactar al individuo nombrado como la persona de contacto de emergencia. **En el caso de que no se pueda localizar a esta persona, se da permiso al proveedor médico seleccionado por el líder adulto del equipo o Director de la Academia encargado de asegurar el tratamiento adecuado, incluyendo hospitalización, anestesia, cirugía o inyecciones de medicamentos para mi hijo/a**. Los proveedores médicos están autorizados a revelar al adulto los resultados del examen, los resultados de las pruebas y el tratamiento proporcionados a los efectos de la evaluación médica del participante, el seguimiento y la comunicación con los padres o tutores del participante y / o la determinación de la capacidad del participante para actividades del programa.

Sin restricciones.
Con consideración especial o restricciones (lista), si las hubiera: _____

I affirm that all the information provided on this 4 page Medical Authorization and Release Form is

accurate and that I understand and give my full and complete permission as listed above.

Afirmo que toda la información proporcionada en este Formulario de Autorizacin y Liberacion Medica de 4 paginas es correcta y que entiendo y doy mi permiso completo como se menciona arriba.

Student's Name_____ Student's Signature_____

Parent's Name_____(print)

Parent's Signature_____Date_____

Remember to attach a copy of your insurance card (front and back) here.