TEMPLE/COURT NAME & NO.:_____

LOCAL TEMPLE/COURT FORM

PARTICIPATION AND MEDICAL AUTHORIZATION FORM

Please print or type. *Note: This PDF form is fillable.*

Date _____

Temple/Court Name _____ Temple/Court City & State _____

Youth's Name _____ Date of Birth _____ ☐ Male ☐ Female

Youth Street Address _____ City _____ State _____ Zip _____

Parent(s)/ Guardian Name _____ Phone # _____

Address if different than youth _____

Physician Name _____ Phone # _____

Dentist Name _____ Phone # _____

MEDICAL HISTORY

1. Has this youth ever had hospitalizations, injury, or serious medical illness? ☐ Yes ☐ No
2. Is this youth now under the care of a physician or taking any medication? ☐ Yes ☐ No
3. Has any physician ever recommended, or do you feel that there should be limits placed on participation in competitive sports? ☐ Yes ☐ No
4. Does this youth have any known allergies to medication? ☐ Yes ☐ No
5. Does this youth wear glasses or contact lenses? Give date of last exam, if Yes. _____ ☐ Yes ☐ No
6. Has this youth ever blacked out or lost consciousness during physical activity? ☐ Yes ☐ No
7. Has the child had a physical examination by a medical provider in the last six months. If yes, list date last seen? _____ ☐ Yes ☐ No

   If Yes to any of the above, please specify:

   _____

8. Allergies/Special Health Considerations _____

PHOTO RELEASE

☐ I grant the Youth Club/Conference agents/staff or affiliates the right to take photographs of my child. I agree that the aforementioned may use such photographs of my child for any lawful purpose, including for example such purposes as publicity, illustration, advertising, social media, and website content.

☐ I do not grant the Youth Club/Conference agents/staff or affiliates the right to take photographs of my child.

I consent to the participation of the above-named youth in the activities and conferences of His/Her youth group, including practice sessions and travel to and from athletics and other activities. I also agree to emergency medical treatment as deemed necessary by the physicians designated by the proper authorities.

_____ _____ _____

Youth Name | Parent/Guardian Signature | Date

RETURN TO YOUTH CLUB DIRECTOR: _____