

TEIA REGISTRATION & MEDICAL RELEASE

One copy per youth

Name of Youth: _____ Sex: _____ DOB: _____

Parent/Guardian Name: _____

Summer address: _____

Home phone: _____ Cell Phone: _____ Email: _____

Siblings in program
(list): _____

IN CASE OF EMERGENCY, CALL

Name/relationship: _____ phone# cell phone

1. _____

2. _____

Physician: _____ Phone: _____

Health Insurance Carrier: _____ Phone _____

Policy & group #'s _____

Please describe any medical conditions or concerns we need to know to work with your child. I.e. allergies, epilepsy, Bee allergies, behavioral concerns:

EMERGENCY MEDICAL RELEASE & CONSENT

In the event of accident, injury or illness to myself, spouse or any child of mine (specifically child named as participant) while participating in any activity sponsored by or under any auspices of TEIA where I am unable to physically consent or am not present: 1. I hereby voluntarily consent to the furnishing to myself, spouse or any of my children of such medical care, attention and treatment by any hospital, physician(s) as they may deem necessary or advisable. 2. I authorize any supervising adult of a TEIA activity to consent to such medical care, attention or treatment. 3. I agree to pay the reasonable cost of such medical care, attention or treatment and to hold free and harmless of and from any and all liability for such cost any supervising adult of a TEIA activity.

I the undersigned, do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any of the medical staff or of a dentist licensed under the provisions of the State Education Law and/or Public Health Law of the state and on the staff of any hospital holding a current operating certificate issued by the State Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care required, but is given to provide authority and power to render care, which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Photography Release

I, the undersigned _____ **give** _____ **do not give** permission for photos taken of my child to be used by TEIA for promotional materials relating to this organization.

Dismissal Policy

At the end of Kid's Camp each day, the above named child will: (check appropriate choice for your family)

_____ **Walk/bike home independently or with family or friend**

_____ **Be picked up by designated individual**

Name of Parent/Guardian: _____

Signed: _____ Date: _____
