



HEALTH CONSENT FORM

****THIS FORM MUST BE COMPLETED AND SIGNED BY PARENT OR GUARDIAN****

REYAP PARTICIPANT: _____

1. PERMISSION FOR MEDICAL TREATMENT, RELEASE OF MEDICAL INFORMATION, AND PAYMENT OF MEDICAL EXPENSES

I REQUEST AND GIVE PERMISSION to the physicians and medical staff to treat the above-named participant appropriately, including hospitalization, prescribing medication, and performing emergency surgical procedures.

I AUTHORIZE release of any medical information to the attending physician and medical staff which may be pertinent to any diagnosis or treatment of the above-named participant.

I ACKNOWLEDGE and understand that the physician, and/or medical staff may use my health information for treatment, payment and healthcare operations.

I UNDERSTAND that any charges resulting from this medical treatment will be billed to me at my address.

Name _____ Policy Number _____

Address _____

NOTE: REYAP does not carry group medical coverage for this program.

Signature of
Parent/Guardian _____ / ____ / ____
Date

2. PERTINENT MEDICAL INFORMATION

Please indicate on the attached form any medical information that might be important for the program and/or medical staff to know. This form will be photocopied, attached to the authorization for emergency care, and carried with REYAP on all trips as well as being placed on file at the REYAP office.

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PERTINENT MEDICAL INFORMATION

Name _____ Sex _____

Date of Birth _____ SS# _____

Address _____

City _____ State _____ Zip _____

Parent or Guardian _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Bus. Phone _____

Name and phone numbers of individual(s) to contact in case of emergency

Medical Insurance Co. _____

Policy Number _____

Please describe any physical condition of the child that precludes physical activity, field work, late night activity, etc.

Please list any medications the student is taking: _____

Please list any allergies (drug/food/environmental): _____

Please describe any conditions of dietary concern: _____
