

TRY - A SPECIAL NEEDS ORGANIZATION MEDICAL/PARENT RELEASE FORM

PARTICIPANT'S NAME _____ SEX M F DATE OF BIRTH _____ AGE _____
 ADDRESS _____ CITY _____ ZIP CODE _____
 PARENT/GUARDIAN _____ ADDRESS _____ CITY _____
 STATE _____ ZIP CODE _____ WORK PHONE (____) _____ HOME PHONE(____) _____
 INSURANCE COMPANY _____ POLICY# _____ SCHOOL ORGANIZATION _____

CURRENT MEDICATION:

NAME OF MEDICATION	EXACT DOSAGE	INTERVAL (GIVEN HOW OFTEN)	PRESCRIBING PHYSICIAN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RELEVANT MEDICAL HISTORY

Please answer the following questions by circling the appropriate answer and if "yes", explain below.

HAS/DOES THE TRY MEMBER:

- | | |
|---|--|
| Y__N__1. Ever been told he/she could not participate in a sport? | Y__N__6. Have Diabetes? |
| Y__N__2. Ever been unconscious or lost memory from a blow to the head? | Y__N__7. Have special behavior traits chaperone should know about? |
| Y__N__3. Ever had a fracture, dislocation or sprain? | Y__N__8. Have Allergies? |
| Y__N__4. Had an acute illness lasting longer than one week? | Y__N__9. Have history of seizure? |
| Y__N__5. Been in the hospital for an operation or other reason? | |
| Y__N__10. Do you have any worries about the TRY member's health or any other questions you would like to bring to the attention of a physician? | |

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN BY FIRST PLACING NUMBER OF QUESTION AND THEN FOLLOW WITH EXPLANATION: (use back of form if necessary)

RELEASE STATEMENT

PARTICIPATION:

I hereby give my permission for the participant named above to participate in any TRY- A Special Needs Organization activity or event of any kind. **NOTE:** If the TRY member is participating in Day Camp he/she must be registered using this release form four (4) weeks prior to start of Day Camp.

MEDICAL:

To the best of my knowledge, full disclosure of the participant's medical history is noted above.

CONSENT TO TREATMENT:

I authorize such physician or medical staff as TRY may designate to carry out any medical or surgical treatment and/or medication necessary, or to take the above named participant to the emergency room of the nearest hospital and I further authorize the physician, hospital, and/or medical staff to provide treatment deemed necessary by them for the well-being of such participant.

RELEASE OF CLAIM:

The physician, organizers, officers, directors, agents, volunteers or employees of TRY, are hereby released, acquitted and forever discharged from any claim for damage or suit by reason of any injury, illness, or damage whatsoever to person or property (during the course of any TRY activity or event of any kind), including transportation to or from the TRY event and in that regard, I hereby covenant that on my own behalf and for the above named participant not to file a claim or bring suit with respect to any such injury or damage.

PERMISSION TO PUBLISH:

I hereby irrevocably grant TRY – a special needs organization permission to record and/or disseminate the above named participant's likeness and/or voice for use by television, films, radio or printed media to further the aims of TRY – a special needs organization. I, the undersigned, am an adult participant or a parent/guardian of the above specified minor participant. I have read and fully understand the provisions of the above release and have explained them to said minor. I hereby agree that I and said minor will be bound thereby.

Date _____

Signature _____
 Parent, Guardian, Staff Care Giver or Adult Participant