

Rotary District 5340 Model United Nations Medical Release Form

Event: Rotary Model United Nations
Event Date: April 11-12, 2015

Student Name: _____

Student Email address: _____

Birth Date: _____ Age: _____ Gender: _____

Telephone Numbers (please list all contact numbers) _____

Complete Address: _____

Parent or Guardian Name: _____

Parent or Guardian Address: _____

Parent or Guardian Telephone Numbers (please include work number):

Parent or Guardian Email Address: _____

Health Insurance Provider: _____

Policy/Group #: _____

**PLEASE ATTACH A COPY OF YOUR HEALTH INSURANCE AND
PRESCRIPTION CARDS-FRONT AND BACK**

List Allergies: _____

List Medical Conditions: _____

List Prescription Medications/Dose: _____

Doctor's Name and Telephone Number: _____

Are there any other health concerns that we should be aware of? _____

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WAIVER STATEMENT: Please check ONE of the following options and sign below.

OPTION 1: _____ I, _____

grant permission to the Rotary District 5340 Model United Nations Committee and its representatives to act on my behalf for _____
(minor student) in granting permission for the evaluation and treatment of any medical issue, accident, and/or emergency that may arise. I understand that should a serious medical problem arise, every attempt will be made to notify me by telephone. In the event that I cannot be reached, I hereby give consent under emergency or life-threatening conditions to such treatment as deemed necessary (including x-rays, specific examinations, surgery, and anesthesia to be rendered to the above-referenced minor by a licensed physician). I understand that for non-life threatening situations, the above-referenced minor's treatment will be determined by the Rotary District 5340 Model United Nations Committee (including the administration of non-prescription medications).

OPTION 2: _____ I, _____

Authorize limited care to said minor as specifically described below:

I, _____ declare that I am the Parent/Legal Guardian of the said minor.

SIGNATURE: _____ **DATE:** _____