Centrum MEDICAL RELEASE FORM required for <u>any</u> student under 18 years of age

Workshop Attending:___________________________________ **Return to Centrum by payment in full due date.**

Name of student ____ Male/Female ______ Age ______
Parent/Guardian names & contact #'s

____ ______-______-______________

____ ______-_____-_______________

Will student bring a Cell Phone? YES/NO If yes - Students Cell Phone # _______-_______-___________________

Emergency contact name & phone number:___________________________________ _____-_____-____________
(*if parent/guardian is not available*)

Allergies: Please list any allergies you have to medications, foods (ie. seafood, nuts, etc.) insect stings or bug/animal bites, or any other concerns we need to be aware of:

******If you carry an Epipen or allergy kit, please initial here if you authorize Centrum to administer the appropriate medications:*
___ YES ___ NO Other instructions:

Medical Information:
Please list below any medical conditions (or special needs related to medical problems) that Centrum needs to be aware of in order to insure a safe and comfortable experience:

Medications: Please list any medications you are currently taking (must be in original container):

Who do you want to administer the medication/s? Please check one-
_____ Parent or Guardian _____ Chaperone _____ Dorm Counselor

Date of last Tetanus Shot: ______________

Insurance Company and Policy Number: ____
(Please send a copy of your insurance card <u>with</u> this form. It is very important to have this in case of an emergency.)

Subscriber Name/Relationship: ____

Parents/Guardians:
In case of medical emergency, I hereby authorize Centrum staff to act in their best judgment to seek medical attention through appropriate means, including emergency room treatment, as deemed appropriate by attending medical personnel. I also accept responsibility for expenses incurred through such treatment.

If this student has a headache or sustains a minor injury while at Centrum, please initial here if you authorize Centrum to administer the appropriate over the counter medications: Tylenol (Acetaminophen), Advil (Ibuprofen), Benadryl, Rolaids, or cough drops: ____ YES ____ NO Other instructions:

_____________________________ _______________________________________ _________________
Parent/Guardian Printed Name Parent/Guardian signature* Date
******If parent/guardian chooses not to sign the medical treatment release for reasons of personal belief, it is necessary to return a written, signed set of instructions of what to do in case of medical emergency.*
Return to: Centrum Registration, PO Box 1158, Port Townsend WA 98368 Fax:360-385-2470