Connecticut Valley Region BBYO
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MEDICAL AUTHORIZATION/CONSENT TO TREAT/MEDICAL ABILITY TO PARTICIPATE

Full name of minor:____ **Grad Year:**_________________

Address:____ **City:**_________________ _________**State:**_____ **Zip:**__________

Home Phone :_______________**Teen Cell Phone:**________________ **Teen Email:** ______________________________

Birth date of minor:________________________________ **Date of last Tetanus Shot:**______________________________

Family physician:____**Phone:**____________________________

Family dentist:____ **Phone:**____________________________

Insurance Company:____**Policy #:**___________________________

Name of policy holder:____

If necessary, describe in detail the nature and severity of any physical and /or psychological ailment, illness, propensity, weakness, handicap, disability or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof.

By my/our signature below, I/we hereby understand and agree as follows:

I/we, ________________________, am the parent or legal guardian having custody of _____________________, a minor child. As such parent or legal guardian, I/we hereby authorize and appoint BBYO, Inc. and its employees, trustees, officers, volunteers, advisors, parent/legal guardian or other chaperones, administrators, faculty or representatives, and their successors and assigns ("BBYO staff"), individuals in whose care the minor child has been entrusted, as my agent to act for me with respect to my/our minor child and in my/our name in any way I/we could act in person to make any and all decisions for me/us with respect to my/our minor child, _________________, concerning my/our minor child's personal care, medical treatment, hospitalization and health care and to require, authorize, withhold or withdraw any type of medical treatment or procedure, including X-ray examination, anesthetic, medical or surgical diagnosis or treatment which may be rendered to my/our minor child under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state or country, whichever is applicable, in which treatment is sought. BBYO staff shall have the same access to my/our minor child's medical records that I/we have, including the right to disclose the contents to others.

I/we, hereby represent that, to the best of our knowledge, information and belief, ____________________ (the minor child) is physically and mentally able to join and serve BBYO as a Member as well as participate in BBYO programs (either as a Member or non-Member) and that minor child has or will have, any necessary examinations prior to joining and/or participating.

Below is specific medical information concerning the minor child. I/we acknowledge that BBYO, Inc. and BBYO staff are relying upon these assurances and information and, by my/our signature below, we hereby certify that this health history (or such other current and sufficient School Health form(s)) submitted on behalf of minor child is correct and accurately reflects the health status of the minor child.[1] **I/we further acknowledge that it is our responsibility to provide BBYO, Inc. and BBYO staff with updated information in writing as necessary and/or as requested.**

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[1] Note – If a parent/legal guardian elects to submit School Health forms, the parents/legal guardian must certify in writing that the information contained in the School Health forms is correct and accurately reflects the health status of the minor child and that the minor child is physically and mentally able to participate in the Programs. BBYO, Inc and BBYO staff reserve the right to refuse to accept School Health forms which are not timely or which do not contain sufficient information.

Name of BBYO participant: ____

Medical Information

Check the following areas of concern for this minor child, if necessary, add another page with details.

1. Does the minor child have allergies to any of the following?

   ______ pollens ______ medications ______ insect bites ______ other allergies (please explain)

2. Does the minor child have any food allergies? Yes No

   If yes, please explain____

3. Does the minor child suffer from, or has ever experienced, or is being treated currently for any of the following?

   ______ asthma ______epilepsy/seizure/fainting condition ______ heart trouble ______diabetes

4. Please list and explain any recent physical or mental illness, injury or infectious condition of the minor child.

   ____

5. Should this minor child's activities be restricted for any reason? Yes No

   If yes, please explain:____

6. Special needs (including dietary):____

7. Please identify all medications which may need to be administered during the minor child's participation in the Program. BBYO's Medication Management policy requires that minor child turn in all medication to the BBYO staff upon arrival. If collected, the BBYO staff (who may not be nurses) will administer the medication in accordance with instructions provided below. The information provided below must be supported by adequate medical documentation from a healthcare provider. The medication will be returned to the minor child upon departure. Please note that BBYO does not have a resident nurse available during its programs and a nurse may not be available to administer the medication.

Name of Med:	Purpose & Dosing Instructions:	Special care required:
______________________________	______________________________	______________________
______________________________	______________________________	______________________

8. Other information about the minor child's behavior and physical, emotional or mental health about which BBYO, Inc. should know:____

Please note that BBYO, Inc. reserves the right to deny membership and/or participation in a program where it does not believe it will be able to accommodate a minor child's restrictions and/or medication needs.

I/we, the undersigned parent or legal guardian of the minor child named above acknowledge that I/we have reviewed the above and confirm that the information is true and correct and that I/we have the authority to execute this MEDICAL AUTHORIZATION/CONSENT TO TREAT/MEDICAL ABILITY TO PARTICIPATE.

Parent/Guardian Signature	Name (printed)	Date	Parent Cell #	Parent Email
Parent/Guardian Signature	**Name (printed)**	**Date**	**Parent Cell #**	**Parent Email**

Additional Emergency Contact if Parent/Guardian cannot be reached:

Name	Relationship to Teen	Emergency Contact #