

## PYO Parental Permission/Release/Medical Treatment Form

I give permission for my child \_\_\_\_\_  
to participate in PYO sponsored events. In the case of injury or illness, I  
authorize \_\_\_\_\_ (Coaches Name) to render  
emergency first aid and/or seek all necessary medical attention for my child.  
In such cases, I understand that I will be notified as soon as possible. I  
certify that my child possesses no physical condition which precludes his or  
her full participation in PYO activities except for the conditions, allergies or  
precautions listed on the reverse of this form and/or on the accompanying  
emergency medical treatment form. I understand that medical personnel and  
first aiders will rely on the completeness of the accompanying medical  
information I have provided.

*Express Liability Waiver:* I understand that outdoor and sports activities  
inherently involve risks that can result in serious injury; I hereby assume the  
risk for all such hazards, and agree to hold harmless and blameless the PYO  
in the event of any injury or illness resulting from my child's participation in  
this activity.

In case of an emergency during this activity, please contact:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number(s)

Alternate (in case above cannot be reached):

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number(s)

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date

## PYO Emergency Medical Treatment Form

Emergency Treatment Release Statement: I hereby authorize PYO's Adult Leadership and/or any licensed physician, EMT or other qualified hospital personnel to render medical treatment to my child \_\_\_\_\_ which, in their judgment, is necessary in the event of illness or injury. I understand that, in all such cases, I will be notified as quickly as possible.

\_\_\_\_\_  
(Signature of Parent or Guardian) (Date)

Child's Full Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

Full Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Father's Work Number: \_\_\_\_\_

Mother's Work Number: \_\_\_\_\_

Additional Permanent Emergency Number: \_\_\_\_\_

Name of person to contact at this additional number: \_\_\_\_\_

Relationship to Family: \_\_\_\_\_

Please list any and all allergies, special medical conditions, special medications or health problems a first aider or medical practitioner should be aware of prior to treatment:

\_\_\_\_\_  
\_\_\_\_\_

Please list any and all medications that your child takes on a regular basis. Please include amounts taken, number of daily doses and routine administration times:

\_\_\_\_\_  
\_\_\_\_\_

Are there any medications that you know of that are contraindicated for medications your child is currently taking on a regular basis?

\_\_\_\_\_

Blood type (if known): \_\_\_\_\_

Does your child wear contact lenses?: \_\_\_\_\_

Name of Family Doctor: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_

Medical Insurance Policy Name and Number: \_\_\_\_\_

Emergency (or Prior Approvals) Phone Number: \_\_\_\_\_