DRW MEDICAL RELEASE FORM

__________________________________________
Name of Child

I acknowledge that there are risks in any student summer program. It is imperative that my child follow instructions of all supervision, communicate any possibility of illness and avoid acts of third parties not under the control of supervisors. I acknowledge that all risks cannot be prevented, and assume those beyond the control of the University staff. I will take responsibility to see that my child is prepared for all activities and is in good health for the duration of the workshop in order to minimize risks to my child or other participants. In case of medical emergency, I understand that every attempt will be made to contact me, my family physician, or the emergency contact named below. However, in the event that I or my named contacts cannot be reached, I give my permission to the adults in charge of the Stetson University Double Reed Workshop to secure emergency medical treatment for my child through Memorial Hospital of West Volusia. I agree to pay for any charges for emergency medical treatment that are not covered by my personal health insurance.

Is it okay to give your child 1-2 Tylenol tablets if they complain of headaches or other minor aches and pains? _____yes _____no

Is it okay for your child to take care of their own medication dose? ___yes ____no
If you checked “no” a staff member must be provided with specific written and signed instructions for your child’s medication upon check-in.

All Emergency Treatment will be handled at:
Memorial Hospital of West Volusia
701 West Plymouth Avenue
Deland FL 32720
Phone: (386) 943-4670
Hotline: (386) 738-5433

_______________________________
Parent/guardian (please print)            ______________________
Date

_______________________________
Signature of parent/guardian

Daytime Phone # (    )_____________Night Phone #(    ) _________

Alternate emergency # (    )_____________________

_______________________________
Doctor’s name and number
Please include a copy of your child’s insurance card.

If your child is taking any prescription medicines or has any allergies, please list them here or on the back of this page.

For your child’s comfort and safety, please indicate any special medical or behavioral conditions we should know about (allergies, medications, injuries or illnesses, etc.)
In addition, please take this opportunity to share any other information about your child that would be helpful our workshop staff.

STATE OF ____________________ COUNTY OF ______________________________

The foregoing instrument was acknowledged before me this ________ day of ______________, 2015 by, ________________________________.

(SEAL) Name of Notary
Personally known_____________
Produced Identification________
Type of Identification Produced_____________