South County Athletic Association
Youth Sports Program

Youth Medical Release Form

This Medical Release Form is authorized for all SCAA youth meetings and activities during the dates specified below:

_____ _____
First Name Last Name Club/Unit Name

_____ _____ to _____
County and State Dates (From / To)

While my child is attending or traveling to or from the SCAA function, I HEREBY AUTHORIZE THE ADULT SCAA COACH OR ASSISTANT COACH, or in his/her absence or disability, any adult accompanying or assisting him/her, TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR SAID MINOR:

Any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act.; or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act,

This authorization shall remain effective until my child completes his/her activities in this program unless sooner revoked in writing. I understand that as a parent/guardian, I will be responsible for the cost of any service or treatment provided.

EMERGENCY CONTACT INFORMATION

_____
Name Relationship to Youth Identified Above

(_____)_____ (_____)_____
Emergency Day Phone (with area code) Emergency Night Phone (with area code)

_____
Mailing Address City State Zip

AUTHORIZATION AND CONSENT AND RELEASE

I hereby certify that my child is in good health and can travel to and participate in all functions of the SCAA Youth Program as described above. I understand is it my responsibility to keep the information on this form updated (including Health History and parent/guardian status) by contacting SCAA.

_____ _____
Signature of Parent/Guardian Date

NON-CONSENT

I do not desire to sign this authorization and understand that this will prohibit my child from receiving any non-life threatening medical attention in the event of illness or accident.

_____ _____
Signature of Parent/Guardian Date

Submission of the medical data is voluntary. However, a signature is required on one or the other of the two signature lines above. Failure to provide the medical information and authorization may result in our inability to provide necessary medical treatment.

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Health History Information

_____ _____ _____/_____/_____
First Name Last Name County Date of Birth

Subject to:	YES	No	Now Have or Have Had	Yes	No
Colds			Heart Trouble		
Sore Throat			Asthma		
Fainting Spells			Lung Trouble		
Bronchitis			Sinus Trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has appendix been removed?		
Wear corrective lenses?			Do you walk in your sleep?		
Is hearing good?					

Date of last Tetanus Vaccination: _____

Please check over-the-counter medications that may be administered:

q Tylenol q Ibuprofen q Cough Syrup q Decongestant q Dramamine
q Antacid q Polysporin q Hydrocortisone q Other: _____

Please identify allergies including allergies to food, medications, and drug reactions:

_____
_____
_____

Please list any disability accommodations you will need in order to participate in this program or activity.

_____
_____
_____

Please list all current medications:

Name of Medication	Dosage	Times Taken

Please include any additional remarks and special instructions to better assist emergency service personnel.
Please explain "yes" answers on this page.

_____
_____
_____