



# YOUTH SERVICES PROGRAM MEDICAL FORM



31 Arbor Way, Ellington, CT 06029 860/ 870-3130

Program Name: **Rive Above Events 2017/18**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
SEX: M F AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_ CELL # \_\_\_\_\_  
GRADE \_\_\_\_\_ SCHOOL \_\_\_\_\_

**\*Below is used for Youth Services statistic use only. All information is confidential\***

**RACE/ETHNICITY:** Caucasian \_\_\_ African American \_\_\_ Hispanic/Latino \_\_\_ Asian \_\_\_  
Native American \_\_\_ Multicultural \_\_\_ Other \_\_\_

**FAMILY:** Birth parents/adoptive parents \_\_\_ Step & birth parent \_\_\_  
Single parent (female) \_\_\_ Single parent (male) \_\_\_ Grandparents \_\_\_ Relative/Guardian \_\_\_  
DCF Guardianship \_\_\_ Foster parent(s) \_\_\_ On own \_\_\_ Joint Custody \_\_\_ Other \_\_\_

### Medical Information:

PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_  
DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_  
HEALTH INSURANCE NAME: \_\_\_\_\_  
HOSPITAL PREFERENCE: \_\_\_\_\_  
ASTHMA \_\_\_ GLASSES \_\_\_ CONTACTS \_\_\_ BRACES \_\_\_  
MEDICATIONS TAKEN REGULARLY: \_\_\_\_\_

**\*Is there anything that could affect your child's experience in the program that we should be aware of, i.e. medical concerns, allergies, physical or social limitations, etc.? Yes \_\_\_ No \_\_\_**

**If yes, please describe** \_\_\_\_\_

### Emergency Contacts including parents:

NAME: \_\_\_\_\_ CELL: \_\_\_\_\_ HOME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
NAME: \_\_\_\_\_ CELL: \_\_\_\_\_ HOME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
NAME: \_\_\_\_\_ CELL: \_\_\_\_\_ HOME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

### Medical Authorization - (Optional)

In all cases requiring emergency treatment, I hereby give my permission to the Ellington Youth Services staff and the Town of Ellington or his/her designee to select a physician for the registered child, if I cannot be reached. I further authorize the physician to proceed with an examination, investigation and hospitalization, necessary treatment of any injury and/or illness and operation if needed. I also understand that the Town of Ellington does not provide accident or health insurance.

### PARENT/GUARDIAN

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

ALL OF THE ABOVE INFORMATION WAS PROVIDED OR APPROVED BY ME AND IS DEEMED TO BE TRUE AND ACCURATE. I HEREBY GIVE MY PERMISSION FOR THE REGISTERED CHILD TO PARTICIPATE IN THE ABOVE INDICATED PROGRAM THROUGH THE TOWN OF ELLINGTON YOUTH SERVICES.

### PARENT/GUARDIAN

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Photos/Videos may be taken at this event that could appear on the Youth Services website or Facebook page or Rise Above Facebook page with no names listed. I give permission for my child to be photographed. I understand no names will be published.

### PARENT/GUARDIAN

SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_