Pennsylvania DeMolay

Medical History and Release

In order to provide for a safe and meaningful experience for all our participants, Pennsylvania DeMolay requires all program participants to submit this medical history and release – to be completed and signed by a parent/guardian. If this form is on file for your child's participation in another event, you may not need to submit a new one. However, a new form is required for every calendar year, or any significant change in health status. Youth may not be permitted to participate in an event without a current release on-site. Please be as detailed as possible. Information will be treated as confidential.

General Information *(this information is generally requested by medical personnel in case of emergency treatment)*

_______________ _______________ _______________ _______________
Name of Participant | Date of Birth | Gender | Social Security Number

_______________ _______________ _______________
Insurance Carrier | Policy Number | Relationship to Insured

____
Insurance Company Pre-certification phone number or contact information

____
Emergency Contact (Parent) | Phone #1 | Phone #2

____
Emergency Contact (Other) | Relationship | Phone #

Medical History *Leave no blanks. If an item does not apply, write N/A. Attach additional sheets if needed.*

Name of Primary Care Physician ______________________ Phone # ______________________

Is participant currently under care for any illness or injury? Explain. ______________________

____

____

Has participant had any surgeries or significant injuries in the past 12 months? Explain. ______________________

____

Does participant have any food, drug, or contact allergies? List, with reactions, where applicable. ______________________

____

____

Does participant have any disability or physical limitations that might affect participation in conference activities or require special arrangements? ______________________

____

Does participant have a ***medical*** need for a ground-floor room or handicapped-accessible bathroom? ______________________

____

____

Please list any special dietary needs or restrictions (medical/religious only): ______________________

____

List any other conditions or concerns we should be aware of: ______________________

____

Medication Information

- For the safety of all our participants, we require that our adult leaders supervise your child's medication during an event. All medication brought to events, prescription or not, must be left in adult care for the duration of the program. Please provide complete dosage/schedule information. No medications are to be left in participant's possession, except those that are for emergency use (for example, a rescue inhaler). Our complete medication policy is appended to this form.

List medications participant takes currently or regularly: ____

____

Will your child be bringing any medications to the conference/event? ________Yes ________No If yes, be sure to complete page three of this release form.

Over-the-counter Medications: I give my permission for my child to have the following over-the-counter medications, or their generic equivalent, as needed during the event. (We will not give excess over-the-counter medications contrary to the express written directions on the packaging). *Initial* those you approve.

For headaches/pain
________Tylenol (Acetaminophen)
________Advil (Ibuprofen)
________Aleve (Naproxen sodium)
________Other (specify) ___________________

For upset stomach, diarrhea, etc.
________Pepto-Bismol (Bismuth liquid or tablets)
________Mylanta/Milk of Magnesia (Mg/Al based antacids)
________Tums/Rolaids (Calcium based antacids)
________Imodium (Loperamide)
________Other (specify) ___________________

For allergic reaction (hayfever, insect sting, etc)
________Benadryl (Diphenhydramine HCl)
________Sudafed (Pseudoephedrine HCl)
________Hydrocortizone cream
________Calamine lotion
________Other (specify) ___________________

For sore throat/cough
________Cough drops/lozenges
________Chloraseptic spray (Phenol)
________Other (specify) ___________________

May we provide your child with sunscreen? Yes / No

Others (specify)____

____

We may also dispense routine first aid items such as non-prescription antibiotic creams, lotions, antiseptics, artificial tears, and so on. Please indicate here if there are any your child may NOT have: ____

____

Note on Attention Span Medications: Please note that some activities may be physically and/or mentally demanding and may include classroom settings and other tasks requiring concentrated attention. Please consider this when making plans regarding your child's attention-related medications for the program.

Parental Authorization

I, the undersigned am the parent or legal guardian of this child, with full authority to make and delegate decisions regarding this child's health. All of the health information recorded on this form is correct, and I have not omitted any health information necessary for the proper care of this child. A physician has examined this child and reviewed this child's general health within the past 12 months. I authorize Pennsylvania DeMolay to provide this child with routine first aid and to administer prescription and non-prescription medications as indicated herein. I authorize Pennsylvania DeMolay to make medical decisions on behalf of this child, including decisions to hospitalize this child, to approve specific medical procedures on behalf of this child, or to transport this child for medical reasons. I understand and agree that any such decisions will be made in consultation with qualified medical personnel if practicable, but that Pennsylvania DeMolay's staff and other agents may make such decisions without the benefit of medical consultation if they find it necessary to do so. I authorize Pennsylvania DeMolay to have access to this child's medical records, and to provide those records to any third parties, as Pennsylvania DeMolay deems necessary to facilitate the care of this child. I waive any claims, for myself and on behalf of this child, against Pennsylvania DeMolay, and/or its agents, arising in connection with any of the activities or decisions authorized above. A photocopy of this signed authorization is as binding as the original. My child may participate in an active camp, sporting, or conference program (check one):

______Without restrictions______ With the following restrictions and/or in keeping with the following special instructions: ____________

____

____

____ ____

Signature and Date Print name of Parent/Guardian

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This page must be completed if your child will be bringing medications to take during the event. Please read the Pennsylvania DeMolay Medication Policy on the next page. This page should be resubmitted for each individual event.

Medication Information and Schedule - For the safety and health of all our participants, PA DeMolay policy requires that all medication (prescription or over-the-counter) be kept in possession of adult leaders or program staff for the duration of the program. Medication will be dispensed to your child at your specified dosages and times.

Please complete the information below for each medication your child will be taking during the conference/event. Take note of the following:

The usual medication schedule for an event is (times are approximate):

Breakfast – between 7:30 and 8:30 AM
Lunch – between 12 Noon and 1 PM
Dinner – between 5:30 and 6:30 PM
Bedtime – between 10 PM and 12 Midnight

Please indicate below when your child's medication(s) should be taken. Specify if a medication is to be taken at an exact time, or if it is to be given at a time other than those listed above.

We need to know whether your child takes each medication as needed or on a routine schedule. If you check "as needed" for a given medication, we will only dispense the medication when your child asks for it. If you check "as scheduled" for a medication, we will remind your child each time a dose is scheduled. Please check only one of these columns for each medication.

Medication	Dose	Time(s)	Special instructions	As needed	As scheduled

All medications should be sent in the original container. We prefer you send only the number of pills needed for the week. If the instructions above differ from the label on the medication *(for example, if the doctor has instructed you to change dosage, but a new prescription has not yet been filled)*, please explain below. Your signature below is your authorization to dispense medication according to your written instructions above.

Variations or other instructions: ____

____

____

I have read the PA DeMolay Medications Policy. I hereby authorize PA DeMolay adult leaders or program staff to dispense my child's medication according to the schedule above.

Parent/Guardian's Signature and Date: ____

Last Name ______________________

First Name ______________________

Pennsylvania DeMolay Medication Policy *- Information for Conferees and Parents*

For the safety and health of all our participants, all personal medications must be kept in the possession of local Chapter Advisors, designated adult leaders or program staff, and dispensed under their supervision. As a result, please be aware of the following policies. This policy applies to all participants under age 18. Upon request, we will also secure and dispense medications for participants over 18. If deemed necessary, we may also require adults to store medications in a secure area.

A parent or other adult will turn over medication to designated adults at the beginning of the program or event, and will receive it back from them at the program's end. Medications will not be turned over to minors unless a supervising adult is present.

All medications should be in original bottle or packaging. Please do not send loose or unidentified pills or pills in "daily dose" type sorters. We must be able to identify medication in order to dispense it. We prefer you send only enough medication for the duration of the event, but it is more important to have properly labeled containers than exact amounts.

Only emergency medications, such as a rescue inhaler or epi-pen, are exempt from this policy. No other medications, prescription or over-the-counter, are to be in participants possession at any time.

Please be certain we know of any ***food or drug allergies*** your child has.

Medications, whether prescription or over-the-counter, ***will only be dispensed according to prescription/package label.*** If medication is to be dispensed contrary to the label on the prescription, a signed statement from the parent is required. A statement from the physician is preferred.

Local Chapter advisors and event staff dispensing medication are usually ***volunteers*** (concerned parents and adults, just like you), and generally do not have advanced medical training. Please give ***complete and clear instructions*** for all medications, as your instructions will be followed exactly.

All medication will be kept under lock and key at all times. A designated adult leader or program staff member will distribute medications according to necessary dosage schedules. Generally, medications will be dispensed at mealtimes and before bed, unless otherwise directed.

If your minor child refuses a dose, we will call you for direction. We cannot force or coerce any participant to take medication. Please indicate whether your child's medications are to be taken on a routine schedule or only as needed/requested.

Over-the-counter medications will only be given to minor participants with express permission of a parent/guardian. You may approve use of certain over-the-counters before the program begins, or we will call you for permission as needed. Conferees over 18 may authorize their own over-the-counter medications.

Depending on the program location, ***medications requiring refrigeration*** can usually be accommodated. Please inform us if your child's medication needs to be refrigerated, and if it requires a specific temperature range.

If your child requires ***injection medications***, such as insulin or others, all needles and syringes, whether used or unused, must remain locked with medications. We cannot dispose of infectious sharps. You are responsible to provide your own sharps container (which we will keep locked for you) and to dispose of it at the end of the conference. Injection medications must be ***self-administered*** –adult leaders and program staff ***may not administer injections*** of any kind.

Adult leaders and program staff cannot administer medications such as suppositories, or any other medication that would require compromising the privacy of a participant. In such cases, a staff member will dispense the appropriate dose, which the participant may then self-administer privately, without supervision.

Any exceptions to this policy must be approved by the Executive Officer of DeMolay in PA. If you have need to ask for an exception, please do not hesitate to contact him, but understand also that, for the good of the Order, some exceptions ***may not be granted***. While we want your child to participate in DeMolay activities, we are not in the medical business, and may deny participation if we feel we cannot adequately provide for the health or safety of all of our participants.

If you have any questions or concerns about your child's medication during a DeMolay program, please ask an adult volunteer or program staff member for assistance. For general questions about this or other PA DeMolay policies, contact PA DeMolay at:

1244 Bainbridge Road; Elizabethtown, PA 17022; 717-367-1536 x 4 or 800-266-8424 (in PA only); **info@pademolay.org**