western youth network
we dare you

155 WYN Way • Boone, NC 28607
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westernyouthnetwork.org

MEDICAL RELEASE

Participant Name: _____Nickname: _____

Date of Birth: _____ Age: _____ [Male] [Female]

Address:_____

Home Phone: _____ Work Phone: _____ Other: _____

Person to Contact in case of emergency: Name _____

Relationship: _____ Phone: (H) _____(W)_____

Do you have any medical condition which would preclude you from participating in any of the activities led by WYN Staff? [Yes] [No]
If yes, explain and state which activities are prohibited: _____
_____

Allergies or Dietary Restrictions (i.e. benadryl or epinephrine): _____
_____

Current Medications (additional authorization will be needed to administer medication during program hours)
_____

Chronic or Recurring medical conditions: _____
_____

Suggestions or Health Related Information for WYN Personnel: _____
_____

Name of Medical / Hospital Insurance: _____

Policy #: _____

Medicaid [Yes] [No] Medicaid Number: _____

Preferred Physician: _____Phone: _____

Preferred Hospital: _____

The information provided on this form is true and complete to the best of my knowledge. I understand and assume all dangers and risks associated with Western Youth Network (WYN) programs and waive all claims or causes of action arising from my or my son/ daughter's participation in the Western Youth Network and do hereby release the Western Youth Network, all persons, and agents from liability which I may ever have against WYN. I hereby give permission for WYN staff to administer First Aid to the extent of their medical scope of practice and/or refer the above name participant for medical care if needed. My child may freely participate in any or all of WYN's activities except as noted above.

Parent/Guardian Signature: _____**Date:** _____

Witness: _____**Date:** _____