Frameworks
POSITIVE YOUTH DEVELOPMENT FROM THE INSIDE OUT

Health History and Medical Release Form

The information on this form is not part of the Applicant acceptance process. This information is gathered to assist in identifying appropriate care for the Applicant. All medical information is confidential. This form must be completed by the parent(s)/guardian of minors and by any adult volunteer or program Applicant. Keep a copy of the completed form for your records. Any changes to this form should be provided to the Program Manager prior to the Applicant's involvement in the Teens In Action SEL Bootcamp. Please make sure you provide detailed, complete and accurate information so that the staff members are aware of your child's needs. This form is kept on-site during the program.

ALLERGIES	**REACTION**	**HOW DO YOU MANAGE THIS?**
Medication:		
Food:		
Environment:		
Other:		

Are there any other relevant medical conditions or medical information Teens In Action staff should know, including but not limited to:

- Physical or psychological limitations
- Recent or routine medical treatment(s)
- Asthma
- Recent injuries
- Therapy or professional counseling
- Diabetes

Anything else that could restrict participation in program activities? ____ Yes ____ No

If yes, please explain:

Dietary Restrictions?

MEDICATIONS:

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire duration of the program. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Does this applicant take medications on a routine basis? ___Yes ___No

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Prescription medication? ___Yes ___No

Over-the-counter medication? ___Yes ___No

If YES please provide the following information: (Attach additional pages for more medications).

Medication Name:	Dosage:	Specific times taken each day:	Reason for taking:

Identify any medications taken during the school year that Applicant does/may not take during the summer: _____

NOTE: *Please fill out as accurately as possible. If medication information is NOT correct, and participant either does not bring prescribed medication, brings a different kind than is listed here, or otherwise has medication that does not match this application, we will be required to contact you during Teens In Action, taking time away from our programming and your child's experience to clarify medications.* ***Please contact Frameworks of Tampa Bay should anything change before the Teens In Action Bootcamp.***

INSURANCE INFORMATION:

Is the Applicant covered by family medical/hospital insurance? ____Yes _____No

If YES, indicate the insurance carrier/plan name: _____

PARENT/GUARDIAN MEDICATION AUTHORIZATION:

I, parent or guardian of _____ (the "Applicant") expressly authorizes any Frameworks of Tampa Bay representative to administer to the Applicant the medications I have listed above. All medication prescribed or over the counter must be given to volunteer staff upon arrival. The information provided on this form is correct and complete to the best of my knowledge, and I authorize the release of the medical information on this form as is pertinent to my child's condition. Moreover, the applicant has permission to engage in program activities except as noted on this "Health History and Medical Release Form.

Signature _____

EMERGENCY RELEASE AGREEMENT A parent /guardian MUST sign this emergency release agreement for any Applicant or volunteer who is younger than 18 years old. Permission to Provide Necessary Medical Treatment or Emergency Care: If any accident, injury or illness occurs which, in the sole judgment of Frameworks representatives, requires immediate medical attention, I hereby consent for any Frameworks representative to obtain such emergency treatment, including hospitalization. I further consent to have my child transported to a medical facility and to the signing of any releases by Frameworks of Tampa Bay representatives that may be required by any medical care provider. I understand that every effort will be made to notify me in the event of an emergency. In the event I cannot be reached in an emergency, however, I hereby expressly give permission to the physician or medical facility selected by the Executive Director or Program Manager to secure and administer treatment, including hospitalization. The medical information I have provided above is complete and accurate to the best of my knowledge.

Signature _____