

Youth Medical Release Form

This Medical Release Form is authorized for AIS Youth participating in functions and activities for the AIS organization within the time period specified below:

Youth First Name Last Name

AIS Organization Name

City and State

_____ to _____
Dates (From / To)

While my child is attending or traveling to or from AIS Youth functions, I HEREBY AUTHORIZE THE ADULT AIS VOLUNTEER LEADER, or in his/her absence, 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 state-licensed physician and/or surgeon.

This authorization shall remain in effect for the time period specified above, unless sooner revoked in writing.

I understand that as parent/guardian, I will be responsible for the cost of any service or treatment provided.

Authorization and Consent and Release

I hereby certify that my child is in good health and able to travel to, and participate in all functions of the AIS Youth program.

Signature of Consenting Parent/Guardian

Date

(_____) _____ (_____) _____

Emergency Day Phone

Emergency Night Phone

Designated Additional Emergency Contacts

First Name Last Name

(_____) _____ (_____) _____

Emergency Day Phone

Emergency Night Phone

First Name Last Name

(_____) _____ (_____) _____

Emergency Day Phone

Emergency Night Phone

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 an accident or illness.

Signature of Non-Consenting Parent/Guardian

Date