Medical Release/Emergency Information and Hold Harmless Agreement

To be completed by parent(s)/legal guardians of all participants under 18 years of age or by participants themselves if 18 years of age or older.

Name of Participant:_____ Date of Birth: _____

Emergency Contact: _____Relationship to participant: _____

Contact's Phone #1:_____ Contact's Phone #2: _____

****Fill out parent/guardian info if you are under the age of 18****

Parent/Guardian Name (print):_____

Address: _____

Daytime Phone: _____ Evening: _____ Cell: _____

The following medical information about this youth participant is for the purpose of obtaining immediate medical attention if necessary.

Regular Medication required (insulin, antihistamine, etc.): _____

Allergies (food, drug, insects, etc): _____

Activities Prohibited by physical limitations: _____

Tetanus shot in the last 10 years? *(Please circle)* Yes No

Other: _____

Is participant currently under a doctor's care?: *(list name/phone)* _____

If insured, please list insurer and policy number: _____

Special Dietary Needs:_____

This certifies that the above-named participant is physically able to participate in activities with the exception of those listed, and that immediate medical attention may be obtained if necessary. By signing below I agree to indemnify and hold harmless and forever release Iowa Pride Network and its directors, officers, and employees and agents against and from any and all claims and damages, suits and proceedings, medical expense of every type, all or part thereof which arise out of or relate to any activities of the participant of Iowa Pride Network, including but not limited to acts or omissions of Iowa Pride Network.

In the event of an emergency, I hereby authorize the above representatives of Iowa Pride Network to engage a licensed doctor to render medical services which may, in the sole discretion of the doctor, be necessary; I further authorize said representatives to take the participant to the hospital if it should seem necessary and agree that I will pay all doctor, hospital and related bills.

*****Only one signature from the participant's parents or guardians is required*****

Signature of Participant or Parent(s)/Guardians if required (if participant is under the age of 18):

_____ **DATE:**_____

This release will be treated as a confidential document.
It will be destroyed thirty (30) days after October 1, 2011 unless there is an event that requires use of this release.