

WYM YOUNG FRIENDS & JR. YEARLY MEETING 2017 PERMISSION FORM

PARTICIPANT'S NAME: _____ AGE: _____

(Please fill out a form for each child/youth participating in WYM Sessions programming. Your child must have this form in order to participate.)

I, _____, am the parent or legal guardian of _____,
Name of parent or guardian Name of minor

I give permission for my child to participate in all the activities at the WYM Young Friends, Jr. Yearly Meeting, and Nursery Childcare for the 2017 WYM Annual Sessions, unless otherwise stated below, and I hereby authorize WYM and their officers, agents, servants, or employees who supervise these activities to consent to medical care for my child. The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and licensed surgeon. It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, and is given to provide authority and power on the part of the supervisor and his/her authorized designee, and exercise his/her best judgment on what is advisable for my child's care, upon advice of such physician, dentist, and surgeon. The completed forms may be photocopied for trips off the grounds.

List any activities your child is not allowed to participate in:

Signature of parent or legal guardian

Date

WYM YOUNG FRIENDS & JR. YEARLY MEETING MEDICAL FORM

HEALTH CARE INFORMATION

Name of family physician _____ Phone _____

Name of dentist/orthodontist _____ Phone _____

Other doctors _____ Phone _____

Is this applicant covered by medical/hospital insurance? YES NO

Insurance carrier _____ Policy Number _____ Group Number _____

Responsible Party _____ Relationship _____ SSN _____

Address (if different than Registered Parent) _____

MEDICAL HISTORY

List any important medical history we may need to know about your child.

List Current Medications and Instructions _____

Any medically prescribed meal plan or dietary restrictions? _____

Allergies (medications, food, & insects, etc.)? _____

EMERGENCY CONTACT INFORMATION

In case of an emergency, notify:

Name _____ Phone _____

Relationship to Child _____