# Yoga Posies **Medical Release Form**

First Name ________________________________ Last Name ________________________________________

Birthday ____ / ____ / ____ Age ___________ Grade this Fall ________ Gender______________

Address _______________________________________________ City ________________________ Zip_______

**Parent Information:**
Parent One: First Name _______________________________ Last Name ________________________________
Phone ________________________________ Alt. Phone ________________________________

Parent Two: First Name _______________________________ Last Name ________________________________
Phone ________________________________ Alt. Phone ________________________________

**IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY:**

Name ________________ Relationship _____________ Phone __________________ Alt. Phone _____________

Doctor _____________________________________ Phone ________________________

**List** any medical concerns over the last 2 years that we should be aware of, i.e.: surgeries, psychological, heart condition, convulsions/seizures, blood disorders, hypertension, mono, broken bones, hospitalizations etc.

______________________________________________________________________________________________

______________________________________________________________________________________________

Activity Restrictions by parent's/physician's advice__________________________________________________

Other information we need to know ______________________________________________________________

**ALLERGIES:** _ Hay Fever _ Poison Ivy _ Insect Stings _ Food: _______________________________________

_ Asthma _ Penicillin _ Other Drugs: ________________________________________________

Medications brought to camp:____________________________________________________________________

Notes on administering medication(s): ____________________________________________________________

Acetaminophen, Ibuprofen, antacids, anti-diarrhea medication, and first aid **MAY / MAY NOT (CIRCLE ONE)** be administered to my child, as needed, by designated staff members.
___________________________________________________________________________

**AUTHORIZATIONS:**
This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted above. I also give permission to the medical personnel selected by Yoga Posies to order x-rays, routine tests and treatment. In the event I cannot be reached in an emergency, I give permission to the physician selected by Yoga Posies to transport, hospitalize, secure proper treatment, order injection, and/or anesthesia, and/or surgery.

Signature of Parent/Guardian ______________________________________ Date _________________________

Home Phone _______________________________