

MEDICAL INFORMATION. AUTHORIZATION FOR MEDICAL TREATMENT AND RELEASE OF ANY LIABILITY

Name of youth attending _____ Age _____ Sex _____

Address _____ Zip _____

Parent/Guardian _____ Home Phone _____ Work Phone _____

If youth is allergic to any medication - list _____

Is youth allergic to stings? _____

Does the youth have any health problems? If so, list _____

If have hospital/medical insurance, name company _____

Policy No. _____

Family Physician _____ Phone _____

Family Dentist _____ Phone _____

I, _____, hereby designate and appoint Allen Melton, Executive Secretary of the
(Parent/Guardian)

Virginia Cooperative Council, and any adult counselors attending, to authorize any doctor and/or hospital

to provide all necessary medical care including emergency treatment or surgery, to my child _____
(Name of Child)

in the event of any sickness or injury occurring from April 13 – 15, 2018 at the Virginia Institute on
Cooperative
Education.

- FURTHER -

I agree to accept full financial responsibility for the reasonable costs of such care and treatment and I release Phil W. Miller and counselors from any liability in connection with the treatment of my child. If the youth needs to return home, the parents will be requested to furnish transportation.

- FURTHER -

We, the undersigned, hereby release The Virginia Cooperative Council, its' Executive Secretary and Counselors from any and all claims for property damage, bodily injury or death occurring, arising out of, or in any way connected with the conference.

(Signature of Parent/Guardian)

(Date)

NOTE: If I drive a vehicle to the conference, I will not drive it while at the conference and will turn my keys in at registration.

Signature of youth scholar: _____

(The student should bring a copy of this information to the conference and turn in at the time of registration.)