PARTICIPANT MEDICAL CONTACT INFORMATION

Must be completed by all participants.
Must be signed by parent or guardian of participants under 21.
Please type or print legibly in ink!

PARTICIPANT NAME: (Last) _____ (First) _____
BIRTH DATE: / / MALE: FEMALE: SS#: _____
HOME ADDRESS: _____
CITY/STATE/ZIP: _____
HOME PHONE: _____ DAY PHONE: _____
CUSTODIAL PARENT/GUARDIAN: _____
HOME PHONE: _____ DAY PHONE: _____
CELL PHONE: _____
HOME ADDRESS (IF DIFFERENT) _____
HEALTH PLAN CARRIER: _____
NAME OF INSURED:_____
RELATIONSHIP TO PARTICIPANT: _____
POLICY HOLDER / INSURANCE ID / SOCIAL SECURITY NUMBER: _____
FAMILY DOCTOR:_____
OFFICE PHONE: _____
FAMILY DENTIST: _____ OFFICE PHONE:_____
SECOND PARENT OR EMERGENCY CONTACT PERSON: _____
RELATIONSHIP TO PARTICIPANT: _____
HOME PHONE: _____ DAY PHONE: _____
CELL PHONE: _____
Please specify if any health insurance pre-certification, notification, or other requirements exist for the participant:
_____
Please provide front and back copy of participant's/card holder's insurance card.

AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE

Must be completed by parents or guardians of participants under 21 years old.

(I) (We), the undersigned parent(s) and/or natural guardian(s) of _____, a minor, do hereby authorize my child's youth leader (and/or any other adult appointed or designated) to

(i)consent to medical, surgical and dental care for such minor child, (ii) consent to any diagnostic tests, medical, surgical or dental procedure or treatment as may be considered therapeutically necessary by the physician, surgeon, dentist or other health care personnel providing care for such minor child, and

(iii) on(my) (our) behalf, to

(a) employ physicians, surgeons, dentists, nurses and other health care personnel as may be deemed necessary for such minor child, (b) admit such minor child to any hospital, clinic, emergency room, laboratory or other health care or diagnostic facility for examination, treatment, surgery or care and

(c) sign all necessary consents and authorizations. It is understood that this authorization is given in advance of the occurrence of any condition or situation which would necessitate any such medical, surgical or dental care being required but is given to provide authority to obtain such care if it should be required. I fully

understand the consequences of the foregoing statements and sign this AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE knowingly, freely and willingly. This authorization shall continue for such time as my child is participating in the North Dakota Fargo Moorhead Junior Derby event.

MEDICAL CONSENT AND LIABILITY AND ACTIVITY RELEASE FORM

Must be completed by all participants or by parents/guardians of participants under age 21.

I understand that the North Dakota District LC-MS Fargo Moorhead Junior Derby for which this MEDICAL CONSENT AND LIABILITY AND ACTIVITY RELEASE FORM is being given is described as: a youth event with large group sessions, small group interaction, contact sport activity and recreation. I hereby consent to participation of myself (or of my child) in the above-described ND District LC-MS Roller Derby activities. I have reviewed the event information regarding the planned activities. I understand that I have a duty to provide primary accident and medical insurance for myself (or for my child) and I declare that I am (or my child is) covered by primary accident and medical insurance. I release and forever discharge, the North Dakota District LC-MS and their agents and servants, successors and assigns, directors, trustees, officers, employees and other representatives from any and all damages and causes of action either at law or in equity that I may have as a result of my (or my child's) participation in, attendance at, and travel to and from Roller Derby. Furthermore, I do hereby expressly stipulate, and agree to indemnify and hold forever harmless the ND District LC-MS, its agents and servants, successors and assigns, directors, trustees, officers, employees and other representatives against loss from any and all present or future claims, demands or actions in law or in ND District LC-MS Roller Derby that may hereafter be made or brought by me or my child, by anyone on behalf of me or my child, by anyone on behalf of me or my child, or by anyone else on their own behalf for damages or any other legal or equitable remedy on account of any injury, illness, physical condition, inconvenience or loss sustained by me or my child during ND District LC-MS Roller Derby or travel to and from it.

I hereby acknowledge that I have read this consent, understand its contents, and have signed it on my own free act and deed.

_____ _____ _____

Parent/Guardian Signature Date Witness

PARTICIPANT EMERGENCY MEDICAL INFORMATION FORM

Please complete so that health providers can be aware of your personal health needs.

Must be completed by all ND District LC-MS Roller Derby participants.

Name of Participant: _____

Does participant have: (if "yes" explain)

____ Yes ___No Allergies? _____

____ Yes ___No Heart Condition? _____

____ Yes___ No Other? _____

Is participant subject to: (If "yes" explain)

____Yes__No Headache? _____

____ Yes ____ No Seizures? _____

____Yes____ No Motion Sickness? _____

____Yes____ No Fainting? _____

____Yes ____No Sleep Walking?_____

____ Yes____ No Upset Stomach? _____

____Yes ____No Other? _____

Does participant have reaction to: (If "yes" explain

____Yes ___No Bee Sting? _____

____Yes ___No Penicillin?_____

____Yes ___No Other Drugs? _____

____Yes ___No Poison ivy? Oak? Sumac?_____

____Yes ___No Other? _____

____ Yes___ No Has the participant had any serious illness or surgery within the past ten years?

Please list: _____

____Yes ____No Does the participant have any condition that would prevent him/her from participating in any ND District LC-MS Roller Derby activities?

Please list: _____

____Yes ____No Does the participant take any prescription medication?

Please list: _____

____Yes ____No Are any drugs ineffective in treatment? _____

____Yes ____No Is the participant diabetic? Medication?_____

____Yes ____No Does the participant have any sight or hearing impairment?_____

____Yes ____No Does the participant wear contact lenses? _____

____ Yes____ No Does the participant wear hearing aids?_____

_____ Date of last tetanus shot: A current tetanus shot is required. After 10 years, another tetanus shot is recommended.

Please indicate ANYTHING else that leaders should know to help avoid or deal with any medical situation that might arise: _____

Parent or Guardian's signature: _____

Date: _____/_____/_____

TIME

Revised: Thursday, January 01, 2015