Northern California DeMolay

MEDICAL HISTORY and RELEASE FORM

Printed Name of PARTICIPANT:____Birthdate: ________________

CHAPTER: ____JURISDICTION: Northern California

I understand that while on my way to, in attendance at, and returning from any DeMolay activity I will fulfill my DeMolay obligations as well as obey any special guidelines of that event. I hereby promise to conduct myself in a responsible manner and abide by the DeMolay rules and regulations, remembering that the future welfare of the Order of DeMolay is in my hands. I will not sell, distribute or possess liquor or any illegal drugs. Article 44 of the ISC Statutes provides for disciplinary measures ranging from reprimand to suspension to exclusion from the Order of DeMolay.

PARTICIPANT's SIGNATURE: **[X]** ____DATE: ____________

The participant is permitted to participate in ALL official DeMolay activities and events WITH THE FOLLOWING EXCEPTIONS (e.g. skiing, swimming. If NONE, write NONE):

____

HEALTH HISTORY

You should be aware that the participant has experienced health problems with the following (check all that apply):

[ ]Appendicitis
[ ]Asthma
[ ]Bones (broken/weak)
[ ]Convulsions
[ ]Cramps in water
[ ]Diabetes
[ ]Ear Trouble
[ ]Epileptic seizures
[ ]Eyes (e.g. needs glasses)
[ ]Fainting
[ ]Frequent colds
[ ]Heart trouble
[ ]Hernia
[ ]Knees
[ ]Motion Sickness
[ ]Rhuematic fever
[ ]Sinus trouble
[ ]Throat infection

Other problems (or NONE): ____

DeMolay maintains medical insurance coverage for accidental injury subject to a maximum of five-thousand dollars ($5,000.00) which is subject to a fifty dollar ($50.00) deductible. Such coverage is not a substitute for any family medical insurance coverage. The participant's family coverage (if there is any) is considered to be PRIMARY COVERAGE with DeMolay's coverage being secondary.

Medical Insurance Company
or Medical Plan (or NONE): ____Policy Number(s): ________________

Phone Number (of family physician, medical plan etc.): (_______)______________________Note: ______________________

In case of an emergency, please contact: *(please print)* **[This section MUST be completed]**

Name: ____ Phone: (________)______________________

Address: ____ Relationship: __________________________

PARENTAL PERMISSION & MEDICAL RELEASE (if the participant is under 18 years of age)

As the Parent or Legal Guardian of the participant named above, I hereby give my permission for any adult DeMolay Advisor in attendance to secure, or any physician in attendance to provide, such emergency medical treatment as shall be deemed necessary by those present; including, but not limited to, hospitalization, injections, anesthesia, surgery, x-ray, blood and medications. I understand that every reasonable effort shall be made to contact me or the emergency contact prior to medical treatment.

I agree that if in the opinion of any DeMolay advisor that the participant should be removed or asked to leave any DeMolay activity for violation of the same, that the undersigned will immediately take the necessary action to cause the transportation of the participant named above from the activity site at the expense of the undersigned Parent or Legal Guardian.

PARENT or LEGAL GUARDIAN's SIGNATURE: **[X]** ____ DATE: ____________

Address/City/Zip: ____

PHONE: (________)__________________________________ RELATIONSHIP: ______________________________

Thank you for filling in all blanks *(particularly the emergency contact section)* and obtaining the necessary signatures.