Media Release/ Medical Treatment Authorization

SECTION I - RELEASE FOR AUDIO, VIDEO, FILM AND PHOTOGRAPHS

All adult and youth participants attending must complete this section of the form. Participants in Otsego Conservation District (OCD) events are sometimes photographed for OCD promotional materials.

I authorize Otsego Conservation District to record and photograph my image and/or voice or that of my child for use by Otsego Conservation District. I understand and agree that these audio, video, film and/or print images may be edited, duplicated, distributed, reproduced, broadcast and/or reformatted in any for and manner without payment of fees, in perpetuity.

Parent name_____

Signature_____
(Parent or guardian must sign if subject is under 18)

Date_____

SECTION II – MEDICAL TREATMENT AUTHORIZATION

This section must be completed and signed by a parent or guardian for all youth participants before they can participate in OCD activities. Please complete this form to give a medical facility permission to treat the participant for minor injuries or medical problems. In the event of serious injury or illness, the parent or person designated will be contacted. Treatment will proceed before contacting the parent or person designated **only if the situation is urgent and does not permit delay**.

Participant's name_____

Birth date_____ Phone_____

Address_____

_____

Grade in School Fall of 2019 _____

Primary physician's name_____

Physician's address_____

_____

Physician's phone_____

HEALTH INSURANCE INFORMATION:

Policy holder's name and relationship to participant

_____

Policy holder's address_____

_____

Insurance company's name and address

_____

_____

Employer's name and address_____

_____

_____

Business phone_____

All policy numbers (please identify)_____

_____

_____

INFORMATION NEEDED ABOUT PARTICIPANT:

Please circle yes or no. If yes, explain below or on another sheet if you need more room.

Yes No Does the participant have any chronic health problem or illness?

_____

Yes No Does he or she have an acute illness now?

_____

Yes No Has the person been treated recently for some medical problem?

_____

List any medications he or she is now taking for treatment of any medical problem_____

_____

Yes No Does the participant have any allergies to medication or local anesthetics?

_____

_____

Yes No Does he or she have any allergies?

_____

Date of his or her last tetanus shot

_____

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OFFICIAL AUTHORIZATION ALLOWS:

I (parent or legal guardian), _____ recognize that while participating in OCD activities, medical treatment on an emergency basis may be necessary for my child, and I further recognize the OCD staff/ volunteers may be unable to contact me for consent for emergency medical care. **I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the circumstances and to assume the expenses of such care.** I also authorize the medical facility to release any and all information to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature of parent/ guardian of minor or of participant age 18 or older Date

_____ _____

Address_____

Phone (where we can call you in an emergency) _____

Phone (where we can reach you the morning of the program if needed) _____

If we are unable to reach you at the number above:

Emergency contact's name_____

Emergency contact's phone_____

Session:

____ July 29 (K-1st Grade)

____ July 30 (2nd – 3rd Grade)

____ August 1 (4th – 6th Grade)

Please use the space below to indicate any other issues of which the camp director should be aware:

*Kids must bring their own lunch. Lunch will **not** be provided.