KARINA ASSOCIATION

Emergency Medical Release Form

This form is required for participation in Meaningful Day Program provided by Karina Association

Please complete each section thoroughly, sign and date.

Participant's Name: _____ _____
Last First

Sex: F ☐ M ☐ Age: _____ Birthdate (MM/DD/YY): _____

Mother's Name: _____ Home Phone # : ( ) _____

Work Phone # : _____ Cell Phone # : ( ) _____

Father's Name: _____ Home Phone # : ( ) _____

Work Phone # : _____ Cell Phone # : ( ) _____

Additional person authorized to be contacted in case of an illness or of an emergency:

Name: _____ Relationship: _____ Phone # : ( ) _____

Allergies – Do you or your child have any allergies to food, medications, insects, etc.? ☐ Yes ☐ No

If Yes, please list: _____

Health Conditions – Have you (Has your child), currently or in the past, been diagnosed with any of the following health conditions (check all that apply):

Asthma	☐ Yes	☐ No	Epilepsy/Seizure Disorder	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Frequent Migraine Headaches	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Attention Deficit-Hyperactivity	☐ Yes	☐ No
Vision/Hearing Problems	☐ Yes	☐ No	Chronic Ear Infections	☐ Yes	☐ No

If Yes, please explain: _____

List any other health condition(s) not listed above: _____

List any medication(s) currently taken by you (your child): _____

Name of Individual's Physician: _____

Physician's Phone # : ( ) _____

Name of Insurance Company: _____ Policy # /Medical #: _____

In case of emergency, take my child to the following hospital (please check one):

☐ Nearest Hospital OR ☐ _____ (name of hospital)

Emergency Release

If, in the judgment of the staff of Karina Association the child named above needs immediate care and treatment as a result of any injury or sickness, I do hereby authorize and consent to any x-ray examination, anesthetic, medical, or surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services.

I do hereby agree to indemnify and hold harmless Karina Association (including its officers, directors, members and/or volunteers) from any claim by any person whomsoever on account of such care and treatment of said child. It is understood that a good faith attempt shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. Further, it is understood that the undersigned will assume full responsibility for any such action, including payment of costs.

Print Full Name of Parent, Guardian	Signature	Date