

For Washington DeMolays: A current Medical Release Form on file with and approved by the Executive Officer of the DeMolay Jurisdiction of Washington may be substituted for this form.

HEALTH HISTORY, RELEASE AND CONSENT FORM

I, the undersigned Parent or Legal Guardian of _____ (Youth) do hereby give my consent and permission for him/her to participate in DeMolay events. I understand this applies to all activities and events of any duly chartered Chapter of the Order of DeMolay, of the DeMolay Jurisdictions, of DeMolay Leadership Conferences, including any activities or events conducted at the state or jurisdictional level, or by the International Supreme Council, Order of DeMolay, WITH THE FOLLOWING EXCEPTIONS: (State EXCEPTIONS on line below.)

In the event of injury or illness to the above named Youth, I, the undersigned Parent or Legal Guardian, hereby authorize any adult DeMolay Advisor in attendance to secure, and 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 prior to medical treatment.

The above named Youth is subject to or has been treated for the following CIRCLED or CHECKED medical problems, and/or is receiving treatment under the supervision of proper medical authorities as follows: (State OTHER MEDICAL PROBLEMS AND ANY MEDICATIONS on the line below.)

- | | | | |
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| <input type="checkbox"/> ADD | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Eyes-glasses or contacts |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Epileptic seizures | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Prone to fainting |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cramps in water | <input type="checkbox"/> Ear trouble | <input type="checkbox"/> Bad knees |
| <input type="checkbox"/> Bones-broken or weak | <input type="checkbox"/> Hernia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Throat infection |

Other and medications: _____

Neither DeMolay International nor any local jurisdiction of the Order of DeMolay, nor any DeMolay Leadership Conference, maintains medical insurance as primary coverage for its members. I understand that we will be responsible for any and all costs of medical treatment incurred by or on behalf of the above named Youth. My family health insurance carrier and policy numbers are as follows:

Insurance Company Name _____

Policy/Group Number(s) _____

Policy Holder's Name _____

I, the undersigned Parent or Legal Guardian, AND the undersigned Youth, do hereby agree that we will abide by the Statutes, Rules, Regulations, and edicts of the International Supreme Council, Order of DeMolay, and its duly authorized representatives. We agree that if in the opinion of any DeMolay Advisor we should be removed or asked to leave any DeMolay activity for violation of the same, that the undersigned Parent or Legal Guardian will immediately take the necessary action to provide transportation from the activity site at the expense of the undersigned Parent or Legal Guardian.

We hereby agree to release and hold harmless the International Supreme Council, Order of DeMolay, the Grand Master of DeMolay International, and its members together with the Executive Officer, staff members and Advisors of the any local jurisdiction of the Order of DeMolay and any DeMolay Leadership Conference, from any and all claims or cause of action which the undersigned has or may have. This specifically includes any and all claims which arrive out of attendance at DeMolay Leadership Conference, including transportation to and from said event

IN THE EVENT OF AN EMERGENCY, AND THE UNDERSIGNED PARENT OR GUARDIAN CANNOT BE REACHED, THE UNDERSIGNED PARENT OR GUARDIAN HEREBY AUTHORIZE THE FOLLOWING PERSON TO ACT ON HIS/HER BEHALF:

Name: _____ Phone: _____

Address: _____ Relationship: _____

Parent or Legal Guardian: Please provide the following information about yourself.

Your full name: _____

Address, City, State, Zip: _____

Relationship to Youth: _____ Phone (Home) _____ (Work/Other) _____

Signature of Parent/Legal Guardian

Signature of Youth

_____ Date _____

_____ Date _____