Pass It Along
Box City Health Waiver

Name _____ Birth Date _____ Sex ___
Parent or Guardian _____ Day Phone _____
Evening Phone _____ Cell Phone _____
Home Address _____ City _____ State _____ Zip _____
Second Parent or Guardian or Emergency Contact _____
Day Phone _____ Evening Phone _____
Cell Phone _____
Home Address _____ City _____ State _____ Zip _____
If neither of the above are available in an emergency, please notify:
Name _____ Day Phone _____
Evening Phone _____ Cell Phone _____

Allergies

_____ Hay Fever _____ Insect Stings
_____ Penicillin _____ Other Drugs
_____ Asthma _____ Other (Specify)
_____ _____

Operation or serious injuries (dates) _____
_____
Chronic or recurring illness or medical condition
_____
Dietary modifications _____
_____
Please list all current medications. All medications must be held by the Youth Advisor; send with instructions. _____
_____
Other diseases or details of above _____

I, the parent/guardian of the child named above, understand that he/she will be attending Box City, a PIA event, with my full knowledge and permission. She/he may participate in all activities, except as I may stipulate in writing to the leader(s) in charge. Further, if in the judgment of the leader(s) in charge, it becomes necessary to obtain medical care (hospitalization, physician or dentist) for my son/daughter, they have my full permission to do so. In addition, I give my full permission to the medical attendant in charge to hospitalize, secure anesthesia, order injections and/or surgery should the need arise. I will assume full responsibility for such arrangements, including payment of expenses incurred thereby and shall indemnify and hold harmless PIA, their employees, agents and/or volunteers from any and all liability with respect thereto. Such medical expenses would be covered by:

_____ Insurance Company _____ Policy # _____

_____ I will pay such medical expenses directly.

Signature of Parent/Guardian _____ Date _____

Printed name _____