YOUTH CHALLENGE
VITAL INFORMATION, MEDICAL HISTORY & MEDICAL RELEASE

Youth Challenge activities are designed to serve children and young adults (up to age 25) with physical disabilities. Individuals must have a physical disability (i.e. cerebral palsy; spina bifida; muscular dystrophy; amputee, orthopedic, visual, or hearing impairment) and must be able to participate in age-appropriate activities. **Youth Challenge currently does not serve children with a transmittable disease, or children who have a cognitive, behavioral, or emotional disability that prevents them from succeeding in Youth Challenge programs.**

Name of Participant ____

Date Completed ____________ Age _____ Grade (if summer, grade in fall) _________

Home Address ____

____

(city) (state)

County ____________________ Zip ______________ Home Phone ( )_______________

Date of Birth ____/____/____ Height _______ Weight _______ Sex (circle) M F

Physical Disability ____

School (name & city) ____

Mother/Guardian

Name ______________________________

Address _____________________________

____

City State Zip

e-mail address _______________________

Employer ___________________________

Home phone _________________________

Work Phone _________________________

Cell Phone __________________________

Father/Guardian

Name ______________________________

Address _____________________________

____

City State Zip

e-mail address _______________________

Employer ___________________________

Home phone _________________________

Work Phone _________________________

Cell Phone __________________________

In case parents or guardians cannot be reached in an emergency…

Emergency Contact #1 (name & relationship to participant) ______________________________

Home Phone ________________________ Cell Phone ________________________

Emergency Contact #2 (name & relationship to participant) ______________________________

Home Phone ________________________ Cell Phone ________________________

Preferred Physician _________________________ Phone Number _____________________

Preferred Dentist ___________________________ Phone Number _____________________

Preferred Hospital __________________________ City of Preferred Hospital _____________

Insurance Company _________________________ Policy Number _____________________

Statement of Present Health

EQUIPMENT: Please check all that apply

[ ] manual wheelchair [ ] power wheelchair [ ] needs assistance pushing wheelchair
[ ] crutches or cane [ ] walker [ ] eyeglasses/contacts
[ ] hearing aid [ ] braces or AFO [ ] prosthesis
[ ] able to walk alone [ ] able to walk with minimal assistance [ ] dependent on others to transfer

COMMENTS (include comments on coordination, if applicable): ____________________________
____

PERSONAL CARE: Please answer all questions by checking YES or NO

Needs to be lifted onto toilet	YES___	NO___	Has a Tracheotomy	YES___	NO___
Bowel Control	YES___	NO___	Uses a Catheter	YES___	NO___
Bladder Control	YES___	NO___	[ ] Self	[ ] Assisted	
Needs Toilet Reminders	YES___	NO___	Has a Feeding Tube	YES___	NO___
Wears diapers	YES___	NO___			

COMMENTS: ____
____

LANGUAGE AND COMMUNICATION: Please check all that apply

[ ] Has difficulty speaking [ ] Has difficulty being understood [ ] Uses communication board
[ ] Uses sign language [ ] Uses eyes for yes and no [ ] No communication needs

COMMENTS: ____
____

EATING HABITS: Please check all that apply

[ ] Needs to be fed [ ] Needs help drinking (i.e. special cup, straw, ect.)
[ ] Difficulty swallowing [ ] Special diet, food restrictions ___________________________

COMMENTS: ____
____

CURRENT MEDICATIONS OR TREATMENTS: Please list any medications (name, amount, and time administered) and treatments required while your child is at Youth Challenge programs.

___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________

Name of Therapist: _______________________ **Phone Number:** ___________________

ALLERGIES (food, insect bites/stings, etc.): YES___ NO___ Explain: _____________
____

SPECIAL INTERESTS AND SKILLS (e.g. hobbies, musical interests, sports, drama, etc.) _____
____
____

MEDICAL HISTORY: Please check all that apply and explain

[ ] Asthma____
[ ] ADD/ADHD ____
[ ] Autism/Asperger's Syndrome/PDD ______________________________
[ ] Dizziness or fainting ____________________________________
[ ] Broken bones ____
[ ] Unable to read ____
[ ] Transmittable disease _______________________________
[ ] Shortness of breath ____________________________________
[ ] Abnormal blood pressure __________________________________
[ ] Heart trouble (murmur, palpitation, pounding heart) __________________
[ ] Nervousness ____
[ ] Mental impairment ____________________________________
[ ] Head injury ____
[ ] Behavioral concerns ____________________________________
[ ] Emotional or psychological concerns ___________________________
[ ] Epilepsy or seizures ____________________________________
[ ] Other ____

Has your child ever been seen by a psychologist/psychiatrist? If yes, please describe why and when. ____
____

Please describe any other medical conditions or concerns not listed above: ____________
____

MEDICAL VERIFICATION AND EMERGENCY INSTRUCTIONS

I certify that the information included herein is complete and accurate to the best of my knowledge.

______________________________ ____________
Parent/Guardian Signature Date

IN CASE OF EMERGENCY, take the following action (select only one of the following boxes):

[ ] I hereby grant my consent to transfer my child to ____________________ (preferred hospital) or the nearest clinic, and call me or, in the event I am unable to be reached, the emergency contacts listed on the front of this medical release form. Follow the instructions of the attending physician.

______________________________ ____________
Parent/Guardian's Signature Date

[ ] I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, TAKE NO ACTION and call me or, in the event I am unable to be reached, the emergency contacts listed on the front of this medical form. Or follow this procedure:

______________________________ ____________
Parent/Guardian Signature Date

YOUTH CHALLENGE
RELEASE OF LIABILITY

The undersigned understands, recognizes, and assumes the inherent risks associated with Youth Challenge's athletic and recreation programs, including the risks associated with transporting participants and volunteers to programs and related activities. In consideration for being permitted to participate as either a participant or volunteer in the recreational programming of Youth Challenge, the undersigned releases, waives, discharges and covenants not to sue Youth Challenge, its trustees, employees, agents, other volunteers, other participants, and if applicable, sponsoring agencies, advertisers, and owners or lessors of premises that host recreational programs from any and all liability arising out of any injury resulting fro my child's participation.

In the event there is a need for emergency medical treatment for the minor participant or volunteer and the undersigned cannot be reached, the undersigned consents to and assumes the financial responsibility for such emergency treatment.

Lastly, the undersigned grants permission for the taking of pictures and videos and the release of general information about the minor participant or volunteers for use in media outlets or publications whatsoever, without there being any liability on the part of Youth Challenge, its employees, trustees, or agents.

I have read the above waiver and release, understand that I give up substantial rights by signing it and sign it voluntarily.

____________________________________ ________________
Parent or Legal Guardian and relationship Date

____________________________________ ________________
Parent or Legal Guardian and relationship Date

Printed name of parent(s) or Legal Guardian: ______________________________

____

Printed name of participant: ______________________________