



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

DOOR COUNTY YMCA STRIVERS
2019-2020 PARENT RELEASE FORM
Release Form Due by October 1st

GYMNAST BIRTHDAY(MM/D/YY): _____

What age will your child be on
April 5, 2020 _____

Gymnasts Name: _____ Home Phone: _____
Mothers Name: _____ Work Phone: _____
Fathers Name: _____ Work Phone: _____

Mother's Home Address: _____
City: _____ State: _____ Zip _____

Father's Home Address: _____
City: _____ State: _____ Zip _____

Emergency Contact

(other than parent - name & phone number of person you authorize your child's care to)

Family Doctor: _____ Office Phone: _____

Food Allergies: _____

Drug Allergies: _____

Any health conditions that the staff needs to be aware of: _____

Is the gymnast currently taking medication(s) Yes ____ No ____

If yes, an Authorization To Administer Medication form is required on the first day of practice (ask for form from coach). All self-medication is prohibited.

ATTENTION

IN CASE OF MEDICAL EMERGENCY: I understand that every effort will be made to contact parents or guardians of gymnast. In the event I cannot be reached, I hereby give permission to the physician selected by the staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child. I certify that the named child is able to participate in all activities unless indicated.

INSURANCE: Parents are responsible for health insurance coverage of children attending meets and camps.

Parents/Guardian Signature: _____ Date: _____



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Door County YMCA | Medication Authorization Form

Child's Name _____

Parent/Guardian's Name _____

MEDICATION REQUIREMENT

Prescription medication must be in the original container with the pharmacist's label marked with the prescription number, date, child's name, and physician's name. All non-prescription medicine must also be labeled with the child's name.

I authorize the administration of the following medication(s) to my child by the YMCA Staff:

Medication _____ Effective from _____ to _____

Time(s) of day medication is to be given _____ a.m. _____ p.m. _____ other

Administration instructions/amounts of each dosage _____

Reason for medication _____

Possible side affects _____

Medication _____ Effective from _____ to _____

Time(s) of day medication is to be given _____ a.m. _____ p.m. _____ other

Administration instructions/amounts of each dosage _____

Reason for medication _____

Possible side affects _____

Please check one or more of the following instructions:

I will pick up any unused medications from the YMCA Staff at the end of each day.

I give the YMCA Staff permission to hold onto my child's medication throughout the season/session.

I will pick up any of the unused medication from the YMCA Staff at the end of the season/session.

I give the YMCA Staff permission to dispose of any unused medication at the end of the season/session.

Parent/Guardian's Signature _____ Date _____

Record of Administration on reverse side of paper.

For confidential use by the Door County YMCA, 2019.

