

MEDICAL TREATMENT AUTHORIZATION

(FOR YOUTH ONLY)

NOTE: For youth this sheet must be filled out by either a parent or guardian and returned with page 1 (Registration Sheet) A copy should also be given to your advisor or chaperone. (NOTE: Advisors or chaperones should retain a copy for their reference. If you have any questions, you may contact Carole Carney (NJHA Executive Secretary) at carole@njha.org Phone 724 479-3254 or Jim Schmidt (NJHA National Program Leader) at schmidt1@uiuc.edu Phone 217 244-5153. All adults also need a completed Medical Treatment Authorization. **NOTE: INFORMATION MUST BE TYPED OR PRINTED. INFORMATION WILL BE KEPT CONFIDENTIAL.**

This form must be completed and signed by a parent or guardian for all youth participants before they can participate in any National Junior Horticulture Association event. If this form is not completed, youth participants will not be allowed to participate. If religious beliefs interfere, please contact Carole Carney.

Participant's Name _____ Date of Birth _____
Address _____ Phone _____
Primary Care Physician's Name _____ Phone _____
Physician's Address _____

HEALTH INSURANCE INFORMATION

Policy holder's name and relationship to participant _____ Relationship to participant _____
Policy holder's address _____
Policy holder's business phone _____
All policy numbers (please identify) _____
If you have HMO insurance please list emergency treatment authorization phone number _____
Insurance Company Name & Address _____

MEDICAL INFORMATION: Complete detailed information about your child's health will help The National Junior Horticultural Association meet the special needs of your child. Please check the following conditions or diseases of which you are aware, and give as much detail as you can. Add additional paper if needed.

Please check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other known conditions |
| <input type="checkbox"/> Animal* | <input type="checkbox"/> Insulin Dependent | <input type="checkbox"/> No known medical problems |
| <input type="checkbox"/> Bee Sting* | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tetanus Shot (Date) |
| <input type="checkbox"/> Environmental* | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Food* | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other Heart Problems* |
| <input type="checkbox"/> Medication* | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> ADD/ADHA |
| <input type="checkbox"/> Other* | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hemophilia |

*Additional comments: _____

Physical limitations: _____

Daily medicine prescribed by a doctor (list the type of medicine for each health problem.)

<u>MEDICATION</u>	<u>DOSAGE</u>	<u>HOW OFTEN</u>	<u>HEALTH PROBLEM</u>

OFFICIAL AUTHORIZATION FOLLOWS:

Please complete this form to give a medical facility permission to treat the participant for minor injuries or medical problems. In the event of serious injury or illness, the parent or person designated will be contacted. Treatment will proceed before contacting the parent or persons designated only if the situation is urgent and do not permit delay.

I (PARENT OR LEGAL GUARDIAN.) _____

do hereby authorize The National Junior Horticultural Association representative to seek any medical or surgical treatment necessary for the care of my child. I also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Parent of Guardian's Parent Signature _____

Date _____ Address _____

Phone: Day _____ Evening _____ Cell # _____

Emergency Contact _____

Phone: Day _____ Evening _____ Cell# _____