

HEALTH FORM/WAIVER IN LIUE OF HEALTH EXAMINATION TO ATTEND CHRYSALIS OR EMMAUS:

DATES OF EVENT _____

I HEREBY GIVE PERMISSION FOR _____
(LAST NAME) (FIRST NAME)

ADDRESS _____

CITY _____ ZIP _____ PHONE _____

To participate in the Chrysalis or Emmaus enterprise of which he/she is enrolled, and do not hold the enterprise or the Nebraska Chrysalis / Emmaus Community responsible for sickness, injury, or death resulting from and physical unfitness of the above named to attend and participate in the Nebraska Chrysalis / Emmaus activities. In case of medical emergency, I understand that every effort will be made to contact the parent/guardian. In the event that I cannot be reached, I hereby give permission to the physician selected by the Director of the event, or Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above.

DATE _____ SIGNATURE OF PARENT / GUARDIAN _____

PARENT / GUARDIAN ADDRESS AND PHONE IF DIFFERENT FROM ABOVE

ADDRESS _____

CITY _____ ZIP _____ PHONE _____

PARTICIPANTS AGE _____ BIRTH DATE _____ HEIGHT _____ WEIGHT _____ GENDER _____

[OPTIONAL] NATIONAL ORIGIN: (CHECK ONE) NATIVE AMERICAN / ALASKAN _____

BLACK _____ ASIAN PACIFIC ISLANDER _____ HISPANIC _____ WHITE _____

Each participant is covered by an excess medical coverage policy, which pays only after the claimant’s primary carrier pays. It will pay the deductible, the co-insurance and the first dollar, if the participant has no other health insurance up to \$5000 per accident or \$1500 per sickness.

Please provide the name of your medical insurance company

_____ number of policy _____

1. Is there a history of chronic infection of nose, throat, ears, sinus, or lungs? Yes ___ No ___ If so, what?

2. Is there a history of heart pathology requiring restricted activity? Yes ___ No ___ If so, indicate the restriction.

3. Is this person subject to any skin disease? Yes ___ No ___ If so, what? _____

4. List allergies to drug, medications, or food _____

5. Has there been recent illness, or exposure to contagious disease? Yes ___ No ___ If so, what?

6. Is this person subject to fainting? Yes ___ No ___ Convulsive seizures? Yes ___ No ___ Nose bleeds? Yes ___ No ___

Cramps? Yes ___ No ___ Asthma? Yes ___ No ___ Is he/she diabetic? Yes ___ No ___ What medication is prescribed for the preceding conditions? _____

7. List any limitations of activity _____

8. Is there any drug or medication to be taken regularly? _____

9. Date of last tetanus shot? _____ 10. Any other information you wish to add?

VIDEO & PHOTOGRAPHS: I give permission for photographs and/or videos of _____ (participants name) to be used by Nebraska Chrysalis / Emmaus.

(Date) _____ (Signature) _____

THIS FORM IS REQUIRED TO BE SENT WITH APPLICATION OR HANDED TO REGISTER AT THE EVENT