TRY- A SPECIAL NEEDS ORGANIZATION
MEDICAL/PARENT RELEASE FORM

PARTICIPANT'S NAME_____SEX____M___F DATE OF BIRTH_____AGE____
ADDRESS_____CITY_____ZIP CODE_____
PARENT/GUARDIAN_____ADDRESS_____CITY_____
STATE_____ZIP CODE_____WORK PHONE (____)_____HOME (____)_____
INSURANCE COMPANY_____POLICY#_____SCHOOL ORGANIZATION_____

CURRENT MEDICATIONS

NAME OF MEDICATION	EXACT DOSAGE	INTERVAL (GIVEN HOW OFTEN)	PRESCRIBING PHYSICIAN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RELEVANT MEDICAL HISTORY

Please answer the following questions by circling the appropriate answer and if "yes", explain below.

HAS/DOES THE TRY MEMBER:

Y N 1. Ever been told he/she could not participate in a sport?
Y N 2. Ever been unconscious or lost memory from a blow to the head?
Y N 3. Ever had a fracture, dislocation or sprain?
Y N 4. Had an acute illness longer than a week?
Y N 5. Been in the hospital for an operation or other reason?
Y N 6. Have Diabetes?
Y N 7. Have special behavior traits chaperone should know about?
Y N 8. Have Allergies?
Y N 9. Have history of seizure?
Y N 10. Do you have any worries about the TRY member's health or any other questions you would like to bring to the attention of a physician?

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN BY FIRST PLACING NUMBER OF QUESTION AND THEN FOLLOW WITH EXPLANATION: (use back of form if necessary)

_____
_____
_____

RELEASE STATEMENT

PARTICIPATION:
I hereby give my permission for the participant named above to participate in any TRY- A Special Needs Organization activity or event of any kind. NOTE: if the TRY member is participating in Day Camp he/she must be registered using this release form four (4) weeks prior to start of Day Camp.

MEDICAL:
To the best of my knowledge, full disclosure of the participant's medical history is noted above.

CONSENT TO TREATMENT:
I authorize such physician or medical staff as TRY may designate to carry out any medical or surgical treatment and/or medication necessary, or to take the above-named participant to the emergency room of the nearest hospital and I further authorize the physician, hospital and/or medical staff to provide treatment deemed necessary by them for the well-being of such participant.

RELEASE OF CLAIM:
The physician, organizers, officers, directors, agents, volunteers or employees of TRY, are hereby released, acquitted and forever discharged from any claim for damage or suit by reason of any injury, illness or damage whatsoever to person or property (during the course of any TRY activity or event of any kind), including transportation to or from the TRY event and in that regard, I hereby covenant that on my own behalf and for the above named participant not to file a claim or bring suit with respect to any such injury or damage.

PERMISSION TO PUBLISH:
I hereby irrevocably grant TRY- A Special Needs Organization permission to record and/or disseminate the above-named participant's likeness and/or voice for use by television, films, radio or printed media to further the aims of TRY- A Special Needs Organization. I, the undersigned, am an adult participant or a parent/guardian of the above specified minor participant. I have read and fully understand the provisions of the above release and have explained them to said minor, I hereby agree that I and said minor will be bound thereby.

Signature_____ Date_____
(Parent, Guardian, Staff Care Giver or Adult Participant)