



# Jack and Jill of America, Incorporated

## Medical Information and Release Form

This form must be completed for all Chapter activities, Regional and National conferences annually.

Chapter \_\_\_\_\_ State \_\_\_\_\_ Region \_\_\_\_\_ Year \_\_\_\_\_

**Important:** This form must be completed for all Chapter activities, Regional and National conferences on an annual basis. It is mandatory for each child/teen and must be signed by a parent or legal guardian before the start of the Program year. It is the role of the Chapter Program Director to ensure a new form is completed for each child/teen at the beginning of the Program year and properly discarded at the end of the same Program year. During the year, all forms must be stored in a locked and secured location.

### Member Information

Mother's Name \_\_\_\_\_ Email Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Father's Name \_\_\_\_\_ Email Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Child/Teen's Name \_\_\_\_\_ DOB \_\_\_\_\_ Child  Teen  Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Medical Information

**Instructions:** Check all that apply. If a condition is checked, please provide details in the space provided.

- Asthma  \_\_\_\_\_
- Diabetes  \_\_\_\_\_
- Heart Disease  \_\_\_\_\_
- Hay Fever  \_\_\_\_\_
- Eating Disorder  \_\_\_\_\_
- Seizures  \_\_\_\_\_
- Drug Allergies  \_\_\_\_\_
- Food Allergies  \_\_\_\_\_
- Physical Limitations  \_\_\_\_\_
- Other  \_\_\_\_\_

Date of Child/Teen's last Tetanus shot (mm/dd/yyyy): \_\_\_\_\_

Please list all medications and dosage currently taken: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Insurance and Physician Information

Insurance Carrier	Policy Holder	Insurance Phone Number
Policy/Group Number	Primary Physician	Physician Phone Number

## Release Information

### Medical Authorization

I, \_\_\_\_\_, parent or legal guardian of \_\_\_\_\_ hereby give my consent for a chaperone or other adult representative of Jack and Jill of America, Inc. or to obtain such medical care as is reasonably necessary for the welfare of my child/teen, in the event of any emergency or other medical occurrence. I request that payment under my medical insurance program be made directly to the site of services rendered. I understand I am financially responsible for fees not covered by this authorization.

### General Release

I, \_\_\_\_\_, the undersigned parent or legal guardian, do hereby release Jack and Jill of America, Inc. including all Chapters, its chaperones or designees from any and all liability which might result from any personal injury claims or cause of action which might result directly or indirectly from my minor child/teen's participation in any activity or trip which may be conducted under the supervision or direction of Jack and Jill of America, Inc.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Minor

\_\_\_\_\_  
Date

**Important Notice:** In accordance to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule regulation, it is important that all parties in receipt of this form, assure that the information contained on this document is properly protected while allowing the flow of health information needed to provide health care and to protect the individual's health and well being. The purpose of the Privacy Rule is to define and limit the circumstances in which an individual's Protected Health Information (PHI) may be used or disclosed. Contents contained on this document should only be discussed or shared with the individual (or their personal representative) or for the treatment activities of any healthcare provider.