APPENDIX 1-A

IM, Inc. - ETEAM
MEDICAL RELEASE FORM

Please complete **ALL** pages of this document.

Full Legal Name:_____ Date of Birth: _____
Passport #: _____ Gender: Male Female

IT IS IMPORTANT THAT THE INFORMATION REQUESTED HERE BE PROVIDED COMPLETELY AND ACCURATELY.
Does/has your teen ever been treated for or had difficulty with any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Trouble	☐	☐	Asthma	☐	☐	Seizures
☐	☐	Diabetes	☐	☐	Bleeding Disorders	☐	☐	Emphysema

Explain any of the above: _____
_____

Explain any other medical conditions not mentioned above, including those that may require special care, medication or diet:
_____
_____

Blood Type: (if known)_____ Date of last Tetanus Booster: _____

Does the participant have allergies to any of the following:?
☐ Medications ☐ Food ☐ Plant ☐ Animal/insect toxin ☐ Other: _____

Please explain any of the above: _____
_____

PRIMARY INSURANCE INFORMATION:

PLEASE ATTACH COPY OF INSURANCE CARD

Primary Health Insurance Carrier: _____
Carrier Address: _____
Policy/Group #: _____ ID#: _____
Subscriber Name: _____ Relationship to Participant: _____

If student is currently under the care of a physician or taking any medication please list below:

Physician Information
Physician _____

Address _____

City _____State _____Zip_____

Phone (___)_____

Medical Information
Treatment _____

List all medications taken routinely (RX or not):

_____

_____

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Primary Emergency Contact: _____Relationship:_____
Address:_____City:_____State:_____
Phone- Home:_____Work:_____Cell:_____
Email:_____

Other Emergency Contact:_____Relationship: _____
Phone – Home:_____Cell:_____

In the event of an emergency, I do hereby give permission to the holder of this Permission Form as a representative of **IM, Inc.** to act in my stead to consent to any medical treatment or hospitalization
of our student as deemed necessary by a licensed physician or emergency personnel. I hereby give permission to any physician or other medical professional, who may be selected by the adult leader in charge, to order x-rays, routine tests, treatment, hospitalize, secure proper anesthesia for, perform emergency surgery or other medical or dental procedures on, or to order injection of the named participant.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority or power on the part of the supervisor and his/her authorized designee, in the exercise of his/her best judgment on what is advisable for the care of the participant, upon advise of such physician, dentist, and surgeon.

I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I also assume the responsibility of payment for any such treatment.

_____ _____
Signature of Primary Emergency Contact Date

_____ _____
Signature of Participant Date

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Please list any prescription medications that the student will taking during ETEAM below. Your signature denotes your wishes as how ETEAM should handle your students medication on site. A "yes" signature relieves all IM staff and volunteers from the responsibility of obtaining and managing prescription medication for the listed student. A "no" signature will require that all medication be given to IM staff and/or team leader to be distributed to student with proper dosage according to this document.

Medication:	Dosage:	Route:
Medication:	Dosage:	Route:
Medication:	Dosage:	Route:
Medication:	Dosage:	Route:
Medication:	Dosage:	Route:

Parental/Guardian permission is required is for student to keep and maintain their prescription medication regimen during ETEAM without supervision of ETEAM Leaders or Staff. Parent or guardian signature required below:

Yes, my student is solely responsible for their medication while at ETEAM.

_____ _____

Signature Date

No, please have ETEAM Team Leaders and/or staff oversee my student's medication while at ETEAM.

_____ _____

Signature Date

Over the counter medications will be kept and distributed by ETEAM leaders per student request. Parental/Guardian permission is required to give any over the counter medications. Parent/Guardian must initial below for approval. In the case that a student may need other over the counter medication, such as cold medicine, etc., ETEAM staff will notify the listed emergency contact for approval of the medication before it is given to the student.

Please indicate by initial which of the following medications are approved for ETEAM Leaders/Staff to give to your student.

Ibuprofen:
Tylenol:
Benadryl:
Antibiotic cream:
Anti-diarrheal:
Tums:
Hydrocortisone Cream:
Naproxen:

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Please note that students are allowed to carry over the counter medications on their person. However, we do ask that students please alert ETEAM staff and leaders during registration to any OTC medication that will be held by the student. We do ask that students do not give medications to other students. ETEAM leaders will have OTC medication at all times. It is on the student's behalf that the ETEAM leaders carry and distribute the above listed medications. Any additional medication not listed above will need to be provided by the student.

PLEASE ATTACH COPY OF INSURANCE CARD

Notary Public Information:

State: _____

County: _____

Date: _____

Notary Public Name:

_____

My commission expires: _____

NOTARY
SEAL

This form must be notarized by a Notary Public before returning to:

IM, INC.
Attn: ETEAM
5233 Mt. View Road Antioch, TN 37013

THIS FORM MUST BE COMPLETED AND RETURNED TO IM, INC. BEFORE YOU CAN PARTICIPATE IN ETEAM!