District 7630 Delegate CONFIDENTIAL Information Packet

RYLA Delegate's Full Name:______________________________

Parent/Guardian Emergency Call Number ______________ Delegate Birth Date ___/___/___

HEALTH INSURANCE INFORMATION

Policyholder's name: ______________________________

Relationship to RYLA delegate: ______________________________

Insurance Company Name: ______________________________

Insurance Company Address: ______________________________

IF HMO, Emergency Treatment Authorization Phone: ______________________________

Employer's Name: ______________________________

Employer's Address: ______________________________

Policy Number(s): ______________________________

Please check yes or no to the following. (If yes, explain; attach an additional page if necessary).

☐ YES ☐ NO Recent treatment for medical problem ______________________________

☐ YES ☐ NO Allergies to medication or local anesthetics ______________________________

☐ YES ☐ NO Recent surgeries or fractures ______________________________

☐ YES ☐ NO Chronic health problems (seizures, asthma, etc.) ______________________________

☐ YES ☐ NO Acute illness ______________________________

☐ YES ☐ NO Allergies to food ______________________________

☐ YES ☐ NO Contacts, glasses or orthodontic appliances ______________________________

☐ YES ☐ NO Immunizations are up-to-date ______________________________

☐ YES ☐ NO Date of last tetanus shot ___/___/___

☐ YES ☐ NO COVID Shots and Booster (Not required, for emergencies only) ______________________________

PLEASE LIST ALL ALLERGIES TO MEDICATIONS

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All Medications currently being taken: (use additional sheet if needed)

PRESCRIPTION MEDICATION brought to the conference **MUST** be in the original container from the pharmacy with the original label and directions attached (or a copy of the prescription from the doctor). All medications (both prescription and OTC) will be turned in at registration, kept securely, and made available as needed/requested.

Name	Dosage	Frequency

I understand my child may require medication for minor medical conditions including headaches, upset stomach, cuts and scrapes, etc. The following over-the-counter medications may be administered to my child, as needed, following suggested dosage guidelines provided by the manufacturer.

INITIAL BELOW ALL MEDICATIONS YOU GIVE PERMISSION FOR YOUR CHILD TO RECEIVE

______ **Tylenol**™ for headaches, muscle aches and pains, cramps

______ **Advil**™ for headaches, muscle aches and pains, cramps

______ **Maalox**™, **Mylanta™** for upset stomach, stomachache, gas, nausea

______ **Tums**™ for stomachache, upset stomach, nausea

______ **Immodium**™ for diarrhea

______ **Pepto-Bismol**™ for nausea, diarrhea

______ **Milk of Magnesia**™ for constipation

______ **Neosporin**™, **Hydrogen Peroxide** for scrapes and cuts

______ **Benadryl**™ (oral) for sinus, allergies, hay fever, rashes

______ **Sore throat spray or lozenges**

______ **Robitussin DM**™

PARENT/GUARDIAN SIGNATURE______________________________ **DATE** _________

AUTHORIZATION FOR TREATMENT: I hereby give permission to medical personnel to order X-rays, routine tests, treatment, and permission to release any record necessary for insurance purposes, and to provide and arrange necessary related transportation for my child listed above. If I cannot be reached in the event of any emergency, I hereby give my permission to the physician to secure and administer treatment including hospitalization for my child listed above. This complete form may be photocopied should my child need to leave the conference.

The health history I have provided for my child listed above is correct and complete to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE______________________________ **DATE** _________

I have reviewed my health record and find it to be correct and complete to the best of my knowledge. I agree to provide all medications (prescription and OTC) at registration and will request medications as needed. I also agree to not participate in any activities my parent or guardian has listed on the RYLA Student Application Form (https://tinyurl.com/7630RYLA).

DELEGATE SIGNATURE ______________________________________ **DATE**_________

RETURN THIS FORM TO YOUR ROTARY CLUB SPONSOR