Ho`omoana - Hawaiian Cultural Summer Camp
Medical Release Form

Please PRINT all information: (please use one form per student)

Student's LAST NAME: _____ First Name: _____

Age: _____ Birth date: _____ / _____ / _____ Male: _____ Female: _____

Health Insurance Company: _____ ID#: _____

Family Doctor or Clinic: _____ Phone: _____

Date of Last Tetanus _____

SPECIAL HEALTH CONSIDERATIONS AND/OR RESTRICTIONS:

Please describe any allergies:_____

_____

List all special health considerations and/or restrictions needed: _____

_____

Medicine that must be administered and when _____

Special dietary needs / restrictions_____

_____

Any physical activity restrictions _____

MEDICAL RELEASE / PERMISSION FOR TREATMENT:

1. In the event that I cannot be reached in an emergency and my child requires treatment, I hereby give permission to any of the Emergency Contacts listed on the Student Registration Form to authorize any medical center and/or health care provider selected by KIAKO Foundation and/or its staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child/children as named above.

2. I also give permission to the KIAKO Foundation and/or its staff to hold on to all medications and make them available to my child during the times they are to be taken.

3. I fully and completely understand that my authorization below releases KIAKO Foundation and/or its staff of any liability of accident incurred by the above named student. I understand that KIAKO Foundation and/or its staff only carries secondary insurance for students and that I will take primary responsibility for any charges occurring in the event the student(s) name above should need any medical attention at any clinic, facility, or hospital.

4. I further agree that if I have a legal dispute with KIAKO Foundation and/or its staff which cannot be settled through discussions between parties, I will attempt to settle the dispute through mediation before a mutually acceptable mediator whose name appears on the registry of names recognized by Oregon courts as qualified persons for mediation assignments.

If you understand and agree with what you have read, please sign your full name on the line below. The above medical information is correct to the best of my knowledge.

_____

Parent/Guardian Signature Authorization Date