TENNIS WITHOUT LIMITS

Medical Release Form

Youth Full Name: _____ **DOB:** _____ **Today's Date** _____

Health History

The information you provide here will be held in the strictest confidence. It will be kept in our confidential records. This information will be shared with other key program staff only on a "need to know" basis. Since this is our first resource in the event of an emergency, it is important that you be a specific as possible.

Child's Doctor's Name: _____

Participant Name: _____

Insurance Information

My child has medical coverage under: ☐ Employer Insurance ☐ Private Insurance ☐ Medicaid ☐ Other

Name of Insurance Company: _____

Name of Policy Holder (First & Lat Name): _____

Policy # _____ Group # _____

For Medicaid

Name of Insurance Company: _____

Member's Name _____ Medicaid ID # _____

Issuer ID # _____ Date Card Sent _____

Allergies & Medical Conditions

Does your child have any allergies (to food, plants, insects, medicines, etc.)? ☐ Yes ☐ No

If yes, please describe the allergy, the severity of the reaction, requested accommodations and what is done to manage them. _____

_____

Does your child have any medical conditions, physical limitations, or psychological disorders (depression, anger, ADD, ADHD, bipolar, etc.) that may affect his/her experience in our program? ☐ Yes ☐ No

If yes, please list describe the condition in detail to assist us in providing the best program experience for your child. _____

_____

Medications (inhalers included)

Tennis Without Limits at this time is not equipped to administer medication. Children that need to take medication must take it before arriving to the tennis courts. The only exception is for children that may need an inhaler from time to time. Children that need an inhaler must always keep the inhaler in their possession and be able to administer the medication on their own. In this instance, we ask that staff is made aware that an inhaler may be needed during the hours of the program.

Does your child have asthma? ☐ Yes ☐ No

If yes, will your child need his/her inhaler during our program. ☐ Yes ☐ No

Past Surgeries & Treatment

Identify all surgeries or similar procedure your child has received and dates. If yes, please describe the condition in detail to assist us in providing the best program experience for your child.

_____

_____