

Dependent Emergency Medical Release Form

Dependent Participants Name:

Last _____ First _____ Middle _____

Gender: M or F

In the event of a medical emergency, I _____
give permission for my child _____ to be evaluated,
diagnosed, treated and given medication in accordance with standard medical practice by
licensed medical personnel. In the event that I cannot be reached in an emergency, I
hereby give permission to medical personnel to hospitalize, secure treatment, give
injections, anesthesia or perform surgery for my child. All medical history information
may be shared with appropriate medical personnel in the event of a medical emergency.

I relieve Cultural Interchanges and the Ladek Zdroj Summer Dance Festival of all
responsibility and consequences that may arise as a result of this treatment. I will not hold
Cultural Interchanges and the Ladek Zdroj Summer Dance Festival or it's administrators
and employees liable in the event of any injury. Further, I agree to accept any and all
financial responsibility as a result of any necessary medical treatment. The accompanying
health history is correct and complete to my knowledge. I give permission for my child to
participate in all dance, hiking, travel and festival activities.

Parent Signature _____ **date** _____

Family Physician _____ **Doctors Phone#** _____

Participants social security number _____

In case of emergency, contact:

Name _____ relationship _____

Home # _____ work # _____ cell# _____

And/or

Name _____ relationship _____

Home # _____ work # _____ cell# _____

My child does have health insurance and the information is below:

(If not, you must purchase travel health insurance and provide us with that information)

Insurance Company _____

Policy holders name _____

Policy holders social security # _____

Relation to participant _____

Policy and/or group # _____

Is preauthorization required? _____ Insurance Co Phone # _____

Did you purchase travel health insurance? _____ If yes please detail below:



CULTURAL
INTERCHANGES

Drug and Food Allergies	Current Medications and what for

Immunization History	Date Received
DPT series	
Booster	
Measles	
Rubella	
Tetanus	
Tuberculin Test	

List any continuing or chronic health problems

List any Physical or learning disabilities

List all surgeries and what year they were performed

Medical History: if you have ever had the following: Please enter any others

Headaches	Hepatitis	High Blood Pressure
Epilepsy/Seizures	Gallbladder Disease	Thyroid Problems
Asthma/Lung Disease	Bladder/Kidney Problems	Recurrent/Chronic Infectious Diseases
Anemia/Bleeding Disorder	Diabetes	Depression or Mental Illness
Ulcer/Colitis	Back/Joint Problems	Heart Condition

Have you had any fractured bones in the last year?

If yes, what bone and when?

Is there anything else we should know?

If yes, what?

Do you have any eating disorders?

If yes, what?