



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

MISSOURI YMCA YOUTH AND GOVERNMENT 2017 STUDENT PARTICIPATION AGREEMENT SIGNATURE PAGE

I, _____, hereby declare that I have read and agree to the following sections within Missouri YMCA Youth and Government Student Participation Agreement:

- Personal Conduct
- Safety
- Fee Payment
- Facilities
- Dress Code
- Transportation
- Media Release
- Discipline Procedures

I also agree that I will meet all deadlines set forth by Missouri YMCA Youth and Government and understand that failing to do so may result in expulsion from the program and a forfeiture of program fees.

Signing this document is an agreement that binds both parent/guardian and student to the policies contained within the Student Participation Agreement. By signing this agreement, I acknowledge all of the contents of this agreement and am bound hereby.

Signature of Parent/Guardian

Signature of Student

Please Print Name

Please Print Name

____ / ____ / ____
Date

____ / ____ / ____
Date

YOUTH AND GOVERNMENT: 2017 MEDICAL FORM - STUDENT

Student Information		
First:	MI:	Last:
DOB: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	School / Delegation:
Emergency Contact Information		
Name:	Relationship:	
Daytime Phone: () -	Evening Phone: () -	
Name:	Relationship:	
Daytime Phone: () -	Evening Phone: () -	
Name:	Relationship:	
Daytime Phone: () -	Evening Phone: () -	
Health History <i>(Check if you have had any of the following)</i>		
Illnesses: <input type="checkbox"/> Diabetes <input type="checkbox"/> Convulsions <input type="checkbox"/> Heart defect/disease <input type="checkbox"/> Ear infections <input type="checkbox"/> Blood/clotting disorder		
Allergies: <input type="checkbox"/> Hay fever <input type="checkbox"/> Insect stings <input type="checkbox"/> Ivy poisoning <input type="checkbox"/> Penicillin <input type="checkbox"/> Other drugs:		
Diseases: <input type="checkbox"/> Asthma <input type="checkbox"/> Chicken pox <input type="checkbox"/> German measles <input type="checkbox"/> Measles <input type="checkbox"/> Mumps		
List injuries and/or operations and dates (use back of form if necessary):		
List any prescription medications and special dispensing needs (use back of form if necessary):		
Doctors & Health Insurance		
Physician:	Phone: () -	
Dentist:	Phone: () -	
Does your family have medical / health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Carrier:	Policy/Group #:	
Parent's / Guardian's Authorization		
YAG advisors have my permission to provide the following medication, or their generic equivalent, in accordance with the recommended dosage and intervals of administration, in the event I cannot be reached to administer this medication in a timely manner. Initial each to indicate approval.		
_____ Regular Strength Tylenol	_____ Benadryl	_____ Pepto-Bismol
_____ Aspirin	_____ Advil	_____ Calamine Lotion
This health history is correct, so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted by me. I hereby give permission to the physician selected by the acting director to order X-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the acting director to hospitalize, secure proper treatment for, and to order injection and or anesthesia and or surgery for my child as named above on this form. I understand that my insurance will cover this expense, or I will assume responsibility.		

_____ / _____ / _____
Signature of Parent/Guardian

_____ / _____ / _____
Date