



Little Traverse Bay Bands of Odawa Indians Permission and Medical Release Form

This Permission and Medical Release Form gives authorization, including traveling to and from, for the LTBB Department and Program and the related event/activities named below during the dates specified below.

First Name

Last Name

Department/Program

Dates (From / To)

to

Event/Activity

While my child or myself is attending or traveling to or from the respective LTBB Department and or Program event or activity, I HEREBY AUTHORIZE THE LTBB STAFF MEMBER, or in his/her absence or disability, any adult accompanying or assisting him/her, TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT. This authorization shall remain effective until the specified event or activity concludes in this department or program unless sooner revoked in writing. I understand that as a participant/parent/guardian, I will be responsible for the cost of any service or treatment provided.

EMERGENCY CONTACT INFORMATION

Name

Relationship

(_____) _____
Emergency Day Phone (with area code)

(_____) _____
Emergency Night Phone (with area code)

Mailing Address

City

State

Zip

AUTHORIZATION AND CONSENT AND RELEASE

I hereby certify that my child or myself is in good health and can be transported, by any means arranged, to and participate in all functions and/or activities that I have authorized on any registration form provided by the LTBB. I understand it is my responsibility to keep the information on this Permission and Medical Release Form updated by contacting the respective LTBB Department or Program.

Signature of Participant/Parent/Guardian

Date

NON-CONSENT

I do not desire to sign this authorization and understand that this will prohibit receipt of any non-life threatening medical attention in the event of illness or accident for my child or myself.

Signature of Participant/Parent/Guardian

Date

PLEASE FILL OUT BOTH PAGES COMPLETELY



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Participant First Name _____ Participant Last Name _____ Date of Birth ____/____/____

Subject to:	YES	No	Now Have or Have Had	Yes	No
Colds			Heart Trouble		
Sore Throat			Asthma		
Fainting Spells			Lung Trouble		
Bronchitis			Sinus Trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has appendix been removed?		
Wear corrective lenses?			Do you walk in your sleep?		
Is hearing good?					

Date of last Tetanus Vaccination: _____

Please check over-the-counter medications that may be administered:

- Tylenol Ibuprofen Cough Syrup Decongestant Dramamine
 Antacid Polysporin Hydrocortisone Other: _____

Please identify allergies including allergies to food, medications, and drug reactions:

Please list any disability accommodations you will need in order to participate in this program or activity.

Please list all current medications:

Name of Medication	Dosage	Times Taken

Please include any additional remarks and special instructions to better assist emergency service personnel.
 Please explain "yes" answers on this page.

