

**WASHINGTON STATE GRANGE**  
**PARENTAL RELEASE AND MEDICAL CONSENT FORM**  
(Please print or type Information)

THIS FORM SHOULD BE KEPT BY THE PERSON IN CHARGE DURING THE ACTIVITY.

Activity \_\_\_\_\_ Date \_\_\_\_\_ Grange \_\_\_\_\_

Member's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Mailing Address \_\_\_\_\_  
\_\_\_\_\_

-----  
Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
-----

Emergency Contact Person \_\_\_\_\_  
Name Phone Relationship

Address (if different than above) \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Group #s \_\_\_\_\_

IF YOU HAVE NO INSURANCE, CHECK HERE

I hereby agree to release the Grange, the representatives, agents, servants and employees from liability for any injury to above named person resulting from any cause whatsoever occurring to above named person at any time while attending the Grange event, including travel to and from the event, excepting only such injury or damage resulting from willful acts of such representatives, agents, servants, and employees.

I further agree to allow the Grange to use photographs of my child taken at the event for press, brochure, or publicity purposes.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
-----

I do voluntarily authorize the Grange representative to administer and/or obtain routine or emergency diagnostic procedures and/or routine or medical treatment for the above named person as deemed necessary by medical judgment.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Notary's Signature (not required for attendance) \_\_\_\_\_ Date \_\_\_\_\_  
-----

**MEDICAL INFORMATION**

This form is for basic information in case of an emergency, liability release, and an authorization of emergency medical treatment. Every effort will be made to contact parents/guardian prior to any medical treatment. NOTE: Most medical facilities will not perform medical treatment on minors without parental consent or legal authorization.

Do you have any known allergies? \_\_\_\_no \_\_\_\_yes If yes, what are you allergic to? \_\_\_\_\_

Do you have any history of allergies, heart conditions, diabetes, asthma, epilepsy, rheumatic fever or other existing medical conditions? Explain. \_\_\_\_\_

Do you have any physical restrictions or conditions that the advisor/chaperone should be aware of? \_\_\_\_no \_\_\_\_yes. If so, explain \_\_\_\_\_  
\_\_\_\_\_