LILLARD FLY FISHING
EXPEDITIONS

Students Name: _____

IMPORTANT INFORMATION & MEDICAL AUTHORIZATION

(To be completed by a parent/guardian)

STUDENT'S NAME _____ DATE OF BIRTH_____

ADDRESS _____

LILLARD FLY FISHING EXPEDTIONS PROGRAM_____

START/END DATE_____

EMERGENCY CONTACTS

NAME_____ HOME PHONE_____

WORK PHONE _____CELL PHONE _____RELATIONSHIP_____

NAME_____ HOME PHONE_____

WORK PHONE _____CELL PHONE _____RELATIONSHIP_____

HEALTH INSURANCE INFORMATION

Insurance Company Name &Address_____

_____

Policy#_____Group#_____

Subscriber Name & DOB_____

Insurance Company Phone_____

IMPORTANT INFORMATION ABOUT YOUR CHILD

1. Can your child swim? YES NO

2. Does your child have any of the following: medication, allergy, food allergy, environmental allergy (insects, hay fever, etc.), or asthma? YES NO If YES, please explain on an attached sheet.

3. On an attached sheet, please describe and list the dates of any operations and/or significant injuries.

PHOTO

Please attach or email a recent photo of your child, with your child's name and program name and year on the back of each photo.

MEDICAL AUTHORIZATION

To the best of my knowledge, all information given is correct and my child/ward has permission to participate in all activities, except as noted by the examining physician (see Health Record) or by me (see attached). I (parent/guardian) on behalf of myself and my spouse (if spouse is also a parent/guardian of the child/ward) understand and agree that Lillard Fly Fishing Expeditions, its directors and leaders have the right to give first aid to my child/ward and to engage the services of a physician, dentist or hospital if they deem it reasonable and necessary. In the case of medical emergency, I hereby give permission to the physician or dentist selected by an authorized representative of Lillard Fly Fishing Expeditions to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my child/ward. Every reasonable effort will be made to contact the parent/guardian in the event of a medical emergency or serious illness and to secure such person's consent prior to treatment. The cost of all such medical/dental services including emergency evacuation and all transportation will be charged to the parent/guardian and paid for by the same. I authorize the release of my child's medical information to Lillard Fly Fishing Expeditions. I give permission for the administration of the medication(s) specified on the Prescription Medications page of the Lillard Fly Fishing Expeditions Health Record to my child by Lillard Fly fishing Expeditions' leaders for the duration of the program.

Lillard Fly Fishing Expeditions' staff may administer the following medications:
(cross out any that you do NOT give consent to):

•Tylenol (or generic equivalent)•Advil (or generic equivalent)•Benadryl (or generic equivalent)
•Epi-pen (or epi-shot)

My child may self-administer: (cross out any that you do NOT give consent to):

•Inhaler (fast-acting rescue) •Inhaler (daily use maintenance) •Epi-pen (or epi-shot)

PARENT/GUARDIAN SIGNATURE _____DATE_____

PRINTED NAME OF PARENT/GUARDIAN_____