DeMOLAY INTERNATIONAL
MEDICAL HISTORY AND RELEASE FORM

Required for all participants *

IDENTIFICATION OF MINOR PARTICIPANT **YEAR 20_____**

NAME _____ **STATUS SQUIRE**

ADDRESS _____

CITY _____ **STATE Florida** **ZIP** _____

DATE OF BIRTH _____ **AGE** _____

I hereby promise to conduct myself in a responsible manner and abide by the DeMolay rules and regulations; and to follow all of the rules pertaining to specific to DeMolay activities. If I do not abide by this promise, I will be subject disciplinary authority, including but not limited to that of being sent home immediately at my own expense. I shall indemnify and hold Florida DeMolay, DeMolay International, its International Supreme Council and all affiliated organizations harmless from and against any and all penalties, losses, costs, damages, suits, judgments, claims, demands, expenses and liabilities of any kind or nature whatsoever, arising directly or indirectly out of or in connection with my attendance at DeMolay activities.

_____ _____

(Participant's Signature) *(Date)*

Health History – ***DeMolay should be aware that this participant has experienced problems with the following:***

☐	Appendicitis	☐	Ear trouble	☐	Frequent Colds	☐	Rheumatic Fever	☐	Convulsions
☐	Epilepsy or Seizures	☐	Heart Trouble	☐	Sinus Trouble	☐	Cramps in water	☐	Fainting
☐	Hernia	☐	Throat Infection	☐	Diabetes	☐	Current Medications (List):		
☐	Other	☐	Food Allergies (List):						

CONSENT AND RELEASE

I, the undersigned parent or legal guardian of the above-named participant, do hereby give my consent and permission for him/her to participate in all activities and events conducted by Florida DeMolay. I agree to release and hold harmless members, advisors and officers of Florida DeMolay and/or DeMolay International, from any and all claims or cause of action, which the undersigned has or may have. In the event of injury or illness to the above-named minor, I hereby authorize any adult Advisor in attendance to facilitate on my behalf, and any physician in attendance to provide such emergency treatment as may be deemed necessary by those present including but not limited to hospitalization, injections, anesthesia, surgery, diagnostic radiology, blood transfusions, and medication. I understand that reasonable efforts shall be made to contact me prior to medical treatment.

_____ _____

(Parent or Legal Guardian's Signature) *(Date)*

I may be reached at the following numbers:

HOME ( ) _____ WORK ( ) _____ CELL ( ) _____

If I am not able to be reached in case of an emergency, please contact:

NAME: _____ RELATIONSHIP _____ CELL ( )_____

MEDICAL INSURANCE INFORMATION

INSURANCE CARRIER: _____ **POLICY HOLDER:** _____

POLICY & GROUP NUMBER: _____