MEDICAL INFORMATION

The information provided below will assist our staff in providing the best care for your child. Check if applicable or allergic.

○ DIABETES	○ ASTHMA	○ CARRIES EPI-PEN	○ ALLERGIC TO PENICILLIN
○ EPILEPSY	○ CARRIES INHALER	○ ALLERGIC TO INSECT STINGS	○ BEHAVIORAL CHALLENGES

OTHER/PLEASE DESCRIBE ANY CONDITION

DIETARY RESTRICTIONS

PLEASE LIST ANY ACTIVITY RESTRICTIONS

NAME AND PURPOSE OF ANY MEDICATIONS

DO ANY MEDICATIONS NEED TO BE GIVEN DURING PROGRAM TIMES?

PLEASE LIST ANYTHING ELSE THAT MAY AFFECT YOUR CHILD'S AFTER-SCHOOL EXPERIENCE (IE. MOVING, DIVORCE, ETC)

PREFERRED HOSPITAL: ○ Billings Clinic ○ St. Vincent Healthcare

FAMILY DOCTOR:

DOC PHONE:

LIABILITY WAIVER

WAIVERS

My Homework B.O.O.S.T. provider is:

Please check one

- O Boys and Girls Clubs of Yellowstone County
- O Friendship House of Christian Service
- O Discover Zone

By signing this document I (we) agree that:

_____ *Initial* In the case of illness or accident the Homework B.O.O.S.T. provider is authorized to secure emergency medical treatment for the child registered here.

_____ *Initial* For internal and external uses, the Homework B.O.O.S.T. provider utilize film, print and digital images of a member or family, which may be taken during involvement in the Homework B.O.O.S.T. program. I consent to such uses & hereby waive all rights to compensation.

_____ *Initial* I am giving up my (or the minor for whom I sign) right to make any claim against the Homework B.O.O.S.T. provider, its agents, employees and volunteers, including the right to sue them, for bodily injury or property damage or any other loss that I might suffer while using the Homework B.O.O.S.T. provider services, except as limited by law.

This application is valid from the date signed until the student has completed 8th grade.	
Parent/Guardian Name (Please Print):	Date:
Parent/Guardian Signature:	
Youth Participant Name (Please Print):	
This application is valid from the date signed until the student has completed 8th grade.	