LIBERATED SUCCESS INC.

Emergency Medical Release Form

This form is required for participation in overnight Liberated Success college tours.

Please complete each section thoroughly, sign and date.

Student's Name: _____ _____
Last First

Sex: F ☐ M ☐ Age: _____ Birthdate (MM/DD/YY): _____

Parent #1 Name: _____ Cell Phone # : ( ) _____

Parent #2 Name: _____ Cell Phone # : ( ) _____

Allergies – Does your child have any allergies to food, medications, insects, etc.? ☐ Yes ☐ No

If Yes, please list: _____

Health Conditions – Has your child, currently or in the past, been diagnosed with any of the following health conditions (check all that apply):

Asthma	☐ Yes ☐ No	Epilepsy/Seizure Disorder	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Frequent Migraine Headaches	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Attention Deficit-Hyperactivity	☐ Yes ☐ No
Vision/Hearing Problems	☐ Yes ☐ No	Chronic Ear Infections	☐ Yes ☐ No

If Yes, please explain: _____

List any other health condition(s) not listed above: _____

List any medication(s) currently taken by your child: _____

Name of Child's Physician: _____

Physician's Phone # : ( ) _____

Name of Insurance Company: _____ Policy # /Medical #: _____

Emergency Release

If, in the judgment of the staff of Liberated Success, Inc. the child named above needs immediate care and treatment as a result of any injury or sickness, I do hereby authorize and consent to any x-ray examination, anesthetic, medical, or surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services.

I do hereby agree to indemnify and hold harmless Liberated Success, Inc. (including its officers, directors, members and/or volunteers) from any claim by any person whomsoever on account of such care and treatment of said child. It is understood that a good faith attempt shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. Further, it is understood that the undersigned will assume full responsibility for any such action, including payment of costs.

_____ _____ _____
Print Full Name of Parent, Guardian Signature Date

LIBERATED SUCCESS INC.

Medication Authorization Form

This form is required for giving medicine to your son/daughter. Please complete each section thoroughly, sign and date.

Student's Name: _____ _____
Last First

Sex: F ☐ M ☐ Age: _____ Birth Date (MM/DD/YY): _____

Parent #1 Name: _____ Cell Phone # : ( ) _____

Parent#2 Name: _____ Cell Phone # : ( ) _____

Name of Medicine: _____ Storage Requirements: __ None __ Refrigerate

Dosage: _____ Time of Day to Give Medicine: _____

Other Instructions: _____

Possible Side Effects: _____

Name of Medicine: _____ Storage Requirements: __ None __ Refrigerate

Dosage: _____ Time of Day to Give Medicine: _____

Other Instructions: _____

Possible Side Effects: _____

Liberated Success, Inc. chaperones designee will dispense medicine to student according to the following guidelines:

- The parent/guardian must bring medicine and related equipment. Do not send medicine by way of the child. Children must not be in possession of over-the-counter or prescription medicine.
- Prescription medicine must be in the original labeled container. The label must include the child's name, the name of the medicine, instructions for dispensing the medicine, and the doctor's name. (Pharmacists can provide a duplicate labeled container with only the dosage to be given while your child is in our care.)
- Over-the-counter medicine must be in the original container and marked with the child's name.
- If your child needs to receive a half tablet, have this done at home or by the pharmacy filling your prescription. We will not cut tablets.
- If the medication must be refrigerated, a cold pack must be sent along with the medication to prevent spoilage.
- Children who self-administer medication still need to have a Medication Authorization Form on file.

I understand the guidelines for dispensing medicine to my child. I authorize the [title of individual] or his/her designee to give medicine to my child according to the directions provided above. I understand that any unused medication will be properly disposed of within 10 days if not claimed after the discontinuation of the medication. No medication will be sent home with my child. I agree to hold Liberated Success, Inc., its employees and agents, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medicine.

_____ _____ _____
Print Full Name of Parent or Guardian Signature Date