Minor Medical Release Form *(Please Print One Form Per Child)*

Participants Name:_____

Preferred Physician:_____

Preferred Hospital:_____

If not available in an emergency, please contact: (please provide at least one emergency contact)

Name:_____ Phone Number: ( ) ____-_____

Name:_____ Phone Number: ( ) ____-_____

Medical Conditions:

_____

_____

_____

Allergies (include food, environmental, and pharmaceutical allergies)

_____

_____

_____

Does your child require medications while participating in Roots

Collective? (i.e. seasonal allergy medication, epipen, inhaler)

_____

_____

_____

Does your child have any activity restrictions based on medical history?

_____

_____

_____

_____ I give my consent to allow Roots Collective to administer and perform minor first aid to my minor child such as, but not limited to, cleaning and dressing minor wounds, applying antibiotic ointment and bandages, treating nosebleeds, flushing eye irritants, etc.

_____In the event of an emergency, I give my consent to Roots Collective to administer first aid until emergency services can be reached. This includes but is not limited to CPR, treating and applying pressure to wounds, and administering epinephrine if prescribed.

_____ I authorize Roots Collective to seek medical attention for my child in the event of an emergency.

Parent/Guardian Signature: _____

Parent Name: _____

Date: _____