YOUTH SHOOTING SPORTS ASSOCIATION (YSSA)

EMERGENCY MEDICAL FORM

Participants Name_____

Address: _____ **City:** _____ **State:**_____ **Zip:**_____

Age:_____ **Sex:**_____ **Birth Date:** _____/_____/_____ **School Grade:** _____

Male/Female *Day* *Month* *Year* *This Year*

Parent / Legal Guardian / Other Emergency Contact:

Name:_____ Relationship: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

HEALTH INFORMATION STATEMENT

Place a "Y" (yes) or "N" (no) in the space to highlight any information you feel staff and/or volunteers may need to maximize the safety and the well-being of the delegate/chaperone. At the end of the list, please give specific information on any items that you placed a "Y" in the space provided or an additional sheet if necessary. Please be specific. In case of emergency, this form may be the only immediate source of accurate, important information.

- ☐ Nervous or Mental (Epilepsy, Emotional Stress, Convulsions)
- ☐ Lung Disease (Asthma, Persistent Cough, Tuberculosis)
- ☐ Disease of the heart of Blood Vessels (Abnormal Blood Pressure)
- ☐ Chest Pain or Shortness of Breath (Heart Murmur, Rumatic Fever)
- ☐ Stomach or Intestinal trouble (Ulcers, Gall Bladder, Liver Disorder, Jaundice, Colitis)
- ☐ Arthritis, Diabetes, Kidney or Bladder Disease
- ☐ Hay Fever or Allergies
- ☐ Allergy to Any Medicines (Including Penicillin, Tetanus)
- ☐ Impaired Sight or Hearing (Chronic Ear Infections)
- ☐ Recent Surgical Operations, Accidents, Injuries.
- ☐ Any Infectious Diseases
- ☐ Skin Diseases
- ☐ Allergies to Food
- ☐ Significant Orthopedic or Neuromuscular Impairment (Loss of Limb, Spinal Cord)
- ☐ Under Ongoing Care of a Physician (List Name and Number Below)
- ☐ Requires Glasses or Contact Lenses
- ☐ Currently taking medication (Any that require Refrigeration, list below)
- ☐ Date of last "TETANUS BOOSTER" _____

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Please provide any detailed information for any items above marked with a "Y". Be Specific.

_____

_____

_____

_____

_____

Family Doctor: _____

Clinic / Hospital Affiliation: _____

City: _____ Phone: (____)_____

Medical Privacy Statement:

It is the intent of the Youth Shooting Sports Association organization to keep any medical information it may have regarding youth participating in any of YSSA's Programs confidential. However, there may be time in which such medical information will be needed and may need to be shared with others. Examples of sharing might include: providing information to medical personnel in the event of an emergency so that a youth may be treated; providing information YSSA, Coaches, Instructors, or volunteers who are coordinating specific activities in the case of a request for reasonable accommodation; and providing information to chaperones or individuals who are responsible for the health and safety of program participants at a specific activity. Except in the case of emergency, prior to sharing any medical information, it may have with those external to the YSSA Organization, every effort will be made to get the permission of the program participant or parent or guardian before such information will be shared if possible.

As a parent or guardian, I understand that if a serious illness/injury develops, medical or hospital care will be given. I further understand that in case of serious illness/injury, I will be notified. However, if it is impossible to contact me, I give my permission for emergency treatment, x-ray or surgery, as recommended by an attending physician.

I understand insurance may not cover all expenses and I will be responsible for payment of any expenses over and above if any coverage is provided.

Parent / Legal Guardian Signature: _____ Date: _____