

THE CONFEDERATED TRIBES OF THE COLVILLE RESERVATION YOUTH DEVELOPMENT PROGRAM



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RELEASE OF LIABILITY, CONSENT TO MEDICAL TREATMENT AND MEDICAL HISTORY FORM

Dear Participants and Parents/legal guardians of Participants:

You and your child have been invited to participate in a wide variety of activities with the Colville Confederated Tribes Youth Development Program (YDP)! Within our community, these certain activities play a huge role in the children and families lives. We welcome you, and are thankful for your participation. We are here to make a positive impact on the lives of many.

In order for you or your child to participate with YDP, it is necessary to have completed a RELEASE OF LIABILITY AND medical history form. These forms can be signed by the participant if over the age of 18 or by the participant's parent/legal guardian if under the age of 18 years old.

- ★ The Youth Development Program will have many activities that will occur off site including, but not limited to: huckleberry picking, fishing, hiking, crafts, movies, and field trips. Transportation will be provided.
- ★ No alcoholic beverages, tobacco, or any use of drugs is permitted during YDP activities or events. Any use of prescription medicine by participants must be reported to staff before the activity/event.
- ★ Participants' parents/legal guardians must provide full disclosure of medical history, including any health conditions, or injuries that could affect the participant's involvement (i.e allergies, medication, recent injuries, etc.).

I, _____, (print name), acknowledge that my participation in Youth Development Activities may involve a risk of injury, including bodily injury and I should not enter or participate unless I am medically able. I hereby for myself, my heirs, representatives or anyone else claiming on my behalf, covenant not to sue, and waive, release, and discharge the Confederated Tribes of the Colville Reservation (CCT), its volunteers, and sponsors, and anyone else acting for or on behalf of CCT or Youth Development Program from any and all claims of liability for death, personal injury, or damage of any kind arising out of my participation in these activities. This Acknowledgement of Risk and Waiver of Liability extends to all claims of every kind whatsoever.

I also consent to emergency treatment in the event of injury or illness. My signature acknowledges that I have read the above waiver and I agree and accept all terms and conditions set forth herein.

Signature: _____

Date: _____

Medical History

Participants Name: _____ DOB: _____ Sex: _____

Address: _____ Phone: _____

Emergency Contact: _____ Phone: _____

1. Do you have any physical complaints or illnesses at this time? yes No
2. Are you currently under the care of a physician or PR actioner of any kind? yes
 No If yes, why:

3. Are you taking any medications? yes No If yes, what kind

4. Do you have diabetes? yes No
 - a. Are you taking insulin? yes No If yes, how much? _____
5. Do you suffer from seizures? yes No
6. Do you have asthma? yes No
 - a. Do you have a mediation/inhaler? yes No
7. Allergies? yes No If yes, what?

 - a. Allergic to bees? yes No

I give permission for the Program/Employment staff to administer the medication for myself or the above mentioned in case of emergency or illness. (Please Check One) Yes:____ No:____

Name of Physician: _____ Location: _____