

**WOMEN'S DEBATE INSTITUTE
AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR**

I/We, parent(s) or legal guardian of

_____ (Student's Name)

_____ (Date of Birth)

_____ (Social Security #)

an unemancipated minor who is a participant in the Women's Debate Institute, do hereby consent to an X-ray examination, anesthetic, medical or surgical diagnosis or treatment and medical care which is deemed advisable by and is to be rendered under the general supervision of any physician or surgeon at nearby medical facilities. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or medical care being required and is to serve as specific consent to any and all such diagnoses, treatment or hospital care which may be deemed advisable. I further authorize the program director or institute supervisors to administer non-prescription analgesics for minor medical problems such as headaches, etc.

_____ (Parent/Guardian Signature)

_____ (Date)

_____ (Witness Signature)

_____ (Date)

(Consent expires six months from date of signing)

COMMERCIAL INSURANCE

Patient Address _____

Street Address

_____ City

_____ State

_____ Zip Code

Patient Phone # _____

Insurance Company _____

Insurance Co. Address _____

Insurance Co. Phone _____

Policyholder's Name _____

Policy # _____

Policyholder's Address _____

Relationship to Patient _____

Contact # _____

Employee Number _____

I hereby authorize the medical facility that performs the treatment to release any medical information that might be needed in connection with payment for medical services. I understand that I am financially responsible for fees not covered by this authorization.

Patient Signature _____

Date _____

Parent Signature _____

Date _____

**WOMEN'S DEBATE INSTITUTE
RELEASE FROM LIABILITY AGREEMENT**

Please read the following information carefully before signing.

All blanks must be completed. Please read the following information carefully before signing.

Activity: _____ Activity Time Period:

Participant Name: _____

Parent/Guardian Name(s): _____

In consideration for allowing Participant to participate in Activity, I/we, as parents and/or guardians of Participant, agree to the following:

Authorize Participant to participate in the Activity for the Activity Time Period stated above.

Release, indemnify and hold harmless the Activity Sponsor and the Women's Debate Institute from any and all damages, except for damages caused by the sole gross negligence or intentional misconduct of employees, arising out of participation of Participant in the Activity.

Prior to the commencement of the Activity, I/we were made aware of the nature of the Activity, had sufficient opportunity to inquire further, and understand the Activity has inherent risks and I/we and Participant assume, on behalf of Participant, all those inherent risks.

While participating in the Activity, Participant is subject to the policies, rules and regulations of the Women's Debate Institute. Possession of fireworks, explosives, any weapon, illegal drugs or alcohol is prohibited and cause for immediate expulsion from the Activity. Further, any Participant repeatedly disobeying Institute policies, rules or regulations may be expelled from the Activity.

The above agreements are binding upon us, our estates, heirs, representatives, and assigns.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Participant Signature _____ Date _____

**WOMEN'S DEBATE INSTITUTE
HEALTH QUESTIONNAIRE**
(To be filled out by Participant's Parent or Guardian)

Participant _____ Birthdate ____/____/____

Address _____ Phone () _____ - _____

Family Physician _____ Phone () _____ - _____

Parent/Guardian _____

Medications – indicate medication(s) which is/are taken on a regular basis:

Medication Name _____ Dosage _____ Directions _____

Medication Name _____ Dosage _____ Directions _____

Explain any “yes” answers below:

Nervous System: Has the participant ever (Please answer Yes/ No.)

1. had a head injury? _____
2. been knocked out or unconscious? _____
3. had a seizure? _____
4. had a stinger, burner, or pinched nerve? _____
5. had any problems with his/her eyes or vision? _____
6. worn glasses, contacts, or protective eyewear? _____

Circulation: Has the participant ever...

7. been dizzy or passed out during or after exercise? _____
8. had chest pain during or after exercise? _____
9. tired out more quickly than their friends during exercise? _____
10. been told he/she has a heart murmur? _____
11. had racing heart or skipped heartbeats? _____
12. had anyone in their family die of heart problems or sudden death before age 50? _____

Respiratory:

13. Does the participant have trouble breathing or cough during or after exercise? _____

Musculoskeletal:

14. Does she frequently have heat or muscle cramps? _____
15. Does she use any special equipment (pads, braces, mouth guards, etc.)? _____
16. Has she had any injuries of any bones or joints? If so, please circle:

Head	Chest	Shoulder	Elbow	Wrist	Hip	Knee	Ankle
Neck	Back	Forearm	Hand	Thigh	Calf	Foot	

17. **Skin:** Does she have any skin problems (itching, rashes, acne, etc.)? _____

General:

18. Has she ever had surgery or been hospitalized? _____
19. Has she had any other medical problems (infectious mono, diabetes, etc.)? _____
20. Is she taking any medications/pills? _____
21. Does she have any allergies (medicines, bees, stinging insects, food)? _____
22. When was the participant's last tetanus shot? _____
23. When was the participant's last measles immunization? _____

Additional space to explain “Yes” answers:

I hereby state that, to the best of my knowledge, my answers to the above questions are correct. I, as parent/guardian, also consent to the examination of the Participant. Any abnormalities will be referred to the Participant's personal physician or appropriate specialist physician.

Signature of Participant _____ Date ____/____/____

Signature of Parent/Guardian _____