THE SUPREME COUNCIL - DEMOLAY INTERNATIONAL
MEDICAL HISTORY AND RELEASE FORM

(Required for all participants under 21 years of age)

IDENTIFICATION OF MINOR PARTICIPANT

STATUS: ◯ ACTIVE DEMOLAY
◯ SQUIRE
◯ VISITOR

NAME _____
ADDESSS _____
CITY _____
STATE _____ ZIP _____ AGE _____

I hereby promise to conduct myself in a responsible manner and abide by the DeMolay rules and regulations; and to follow all of the rules and regulations of this DeMolay event. If I do not abide by this promise, I will be subject to being returned home immediately at my own expense. I shall indemnify and hold DeMolay International, The International Supreme Council of the Order of DeMolay, and all Affiliated Organizations harmless from and against any and all penalties, losses, costs, damages, suits, judgments, claims, demands, expenses and liabilities of any kind or nature whatsoever, arising directly or indirectly out of or in connection with my attendance at this DeMolay event.

_____ _____
(Participant's Signature) *(Date)*

Health History – *DeMolay should be aware that this participant has experienced problems with the following:*

☐	Appendicitis	☐	Ear trouble	☐	Frequent Colds	☐	Rheumatic Fever	☐	Convulsions
☐	Epileptic Seizures	☐	Heart Trouble	☐	Sinus Trouble	☐	Cramps in water	☐	Fainting
☐	Hernia	☐	Throat Infection	☐	Diabetes				
☐	Other	☐	Food Allergies						

CONSENT AND RELEASE

I, the undersigned Parent or Legal Guardian of the above identified minor, do hereby give my consent and permission for him/her to participate in all activities and events conducted by _____, I agree to release and hold harmless members, advisors and officers of DeMolay International, from any and all claims or cause of action, which the undersigned has or may have. In the event of injury or illness to the above named minor, I hereby authorize any adult Advisor in attendance to secure, and any physician in attendance to provide, such emergency treatment as may be deemed necessary by those present including but not limited to hospitalization, injections, anesthesia, surgery, diagnostic radiology, blood transfusions, and medication. I understand that reasonable efforts shall be made to contact me prior to medical treatment.

_____ _____
(Parent or Legal Guardian signature) ***(Date)***

I may be reached at the following numbers during the above-described event.

HOME _____ **WORK** _____ **OTHER** _____

Medical Insurance Information

Insurance Carrier: _____ **Policy Holder:** _____

Policy/Group Number: _____

For Emergency Authorization Contact: _____

Telephone Number: _____

DEMOLAY INTERNATIONAL ®