THE SUPREME COUNCIL - DEMOLAY INTERNATIONAL
MEDICAL HISTORY AND RELEASE FORM

(Required for all participants)

IDENTIFICATION OF ADULT PARTICIPANT

STATUS: ◯ SENIOR DEMOLAY ◯ ADVISOR ◯ 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 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 participant, 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.

______________________________ ______________________________

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

Emergency Contact Information

NAME ________________ **CELL** ________________ **OTHER** ____________

Medical Insurance Information

Insurance Carrier: ____________________ **Policy Holder:** ________________________

Policy/Group Number: ________________

For Emergency Authorization Contact: ______________________________

Telephone Number: ______________________________

DEMOLAY INTERNATIONAL ®