

**DEMOLAY IOWA
MEDICAL HISTORY AND RELEASE FORM**

All Star 2024

NAME OF PARTICIPANT: _____ CHAPTER: _____

ADDRESS: _____ CITY: _____ PH: _____

*** PARTICIPANT'S INDEMNIFICATION ***

(REQUIRED BY ALL PARTICIPANTS)

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. In consideration of the DeMolay Staff accepting this registration, I shall indemnify and hold IOWA DeMolay, The International Supreme Council of the Order of DeMolay, all Affiliated Organizations and the DeMolay Staff harmless from and against any and all penalties, losses, costs, damages, suits, judgements, 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 ***

The DeMolay Staff should be aware that this participant has experienced health 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 _____ Name
of Medical Insurance Family Physician: _____ Company
_____ Address: _____ Medical Insurance
Policy City: _____ State ___ Zip _____ Number _____
Phone # _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Phone No: Day: AC _____ - _____
Address: _____ Night: AC _____ - _____
City: _____ State ___ Zip _____ Cell: AC _____ - _____

*** PARENTAL PERMISSION & MEDICAL RELEASE ***

(Required For All Participants Under **21** Years of Age)

As the Parent or Legal Guardian of the participant named above, I hereby give my permission for the DeMolay Staff to enter the above named participant into a hospital of their choosing. They may also obtain medical attention or treatment by a physician, if in their opinion, the above named participant needs medical attention or treatment. I also realize that DeMolay members attending this event may be engaged in indoor and outdoor activities and other physical activities related to this event.

To the best of my knowledge, there is no reason why the above named participant should not be allowed to participate in the DeMolay activities.

I also agree, upon notification from the DeMolay Staff, to pick up the above named participant, if, in the opinion of the DeMolay Staff, it is necessary that he/she be removed from the site of this DeMolay event. In addition, I agree on behalf of the above named participant, that he/her room may be entered if it is deemed necessary by the DeMolay Staff.

In consideration of the DeMolay Staff accepting this registration, I shall indemnify and hold IOWA DeMolay, The International Supreme Council of the Order of DeMolay, all Affiliated Organizations and the DeMolay Staff harmless from and against any and all penalties, losses, costs, damages, suits, judgements, claims, demands, expenses and liabilities of any kind or nature whatsoever, arising directly or indirectly out of or in connection with the above named participant's attendance at this DeMolay event.

PARENT or LEGAL GUARDIAN (SIGNATURE) _____

DATE: _____

ADVISOR (SIGNATURE) _____

DATE: _____