**FORM 89**

OMEGA PSI PHI FRATERNIYT, INC.

# Medical, Consent Forms and Releases

Name of Applicant: ______________________________________________
LAST FIRST MIDDLE INITIAL

Home Address: ________________________________ City ____________
State ____________________ Zip ____________________
Sponsoring Chapter/address ______________________________________
______________________________________

Responsible Party in Chapter: Name __________________ Title ____________
Address ____________________ City____________ State ________ Zip ______
Telephone: Home (     ) __________________ Business (     ) ______________

MEDICAL EXAMINATION *Date of Examination ____________________
Doctor's Physical Examination Applicant's Date of Birth __________________
Height ____________ Weight ____________ Blood Pressure ________________

| | NORMAL | ABNORMAL | COMMENTS |
|---|---|---|---|
| Eyes | ________ | ________ | ________________ |
| Ears | ________ | ________ | ________________ |
| Nose, Throat | ________ | ________ | ________________ |
| Heart, Lungs | ________ | ________ | ________________ |
| Abdomen | ________ | ________ | ________________ |
| Extremities | ________ | ________ | ________________ |
| Neurological | ________ | ________ | ________________ |

Allergies to Medication: ________yes ________No If yes, please list:

Restrictions: __________________________________________________

Physician's NAME (print) ________________________________________
ADDRESS: __________________ CITY __________________
STATE __________ ZIP ________ PHONE (     ) ______________
Physician's Signature ___________________________________________

Parent/Guardian (NAME): ______________________ PHONE: H (     ) __________
ADDRESS: ______________________ CITY ____________ B (     ) __________
STATE ____________________ ZIP ____________________
(*Examination must not have been given more than six months prior to activity.
Date(s) of activity is/are ______________________.)

Emergency Contact, if parent/guardian not available:

Name: __________________________ Address: __________________________
State __________ Zip__________ Phone H. (     )__________ B. (     ) __________
Name: __________________________ Address: __________________________
State __________ Zip__________ Phone H. (     ) __________ B. (     ) __________

Family Doctor: Name ________________________ Phone (     ) ______________
ADDRESS: ______________ CITY ______________ STATE ________ ZIP __________
Medical Insurance Policy Name: ____________________ Policy #__________________

To be answered by parent or guardian: (CIRCLE ONE)

**DOES YOUR CHILD HAVE OR HAS HE EVER HAD:**

| | | | |
|---|---|---|---|
| 1. | Sickle Cell Anemia? | YES | NO |
| 2. | Food/medication allergy? | YES | NO |
| 3. | Epilepsy, seizures, fainting spells? | YES | NO |
| 4. | Heat stroke or heat exhaustion? | YES | NO |
| 5. | Diabetes mellitus (sugar) or juvenile diabetes? | YES | NO |
| 6. | Hemophilia (bleeding disorder)? | YES | NO |
| 7. | Bone or joint problems? | YES | NO |
| 8. | Heart problem? | YES | NO |
| 9. | Hearing or vision problem? | YES | NO |
| 10. | Eye glasses, contact lens? | YES | NO |
| 11. | Dentures or hearing aid? | YES | NO |
| 12. | Loss of function of a bodily part? | YES | NO |
| 13. | Require a special diet? | YES | NO |
| 14. | Special psychiatric conditions (Schizophrenia or Depression)? | YES | NO |
| 15. | High blood pressure, hypertension? | YES | NO |

If the answer to any of the above is "Yes," explain fully below. Give details as to when the event occurred, your child's current status and any special needs that he now has.

______________________________________________
______________________________________________
______________________________________________
______________________________________________

Medications:

| | NAME | EXACT DOSAGE | SPECIFIC TIME GIVEN |
|---|---|---|---|
| 1. | ____________ | ____________ | ____________ |
| 2. | ____________ | ____________ | ____________ |
| 3. | ____________ | ____________ | ____________ |

Allergies:
List: ______________________________
Tetanus Booster:
Date: ______________________________

## PARTICIPATION/MEDIA RELEASE

I hereby give my permission for (child's name) ______________________________ to participate in the Omega Psi Phi Fraternity, Inc. activities and events. I also grant to the Omega Psi Phi Fraternity, In. permission to record my child/ward's likeness and/voice for use by television, films, radio or printed media to further the aims of the Omega Psi Phi Fraternity, Inc. in related campaigns, magazine articles, booklets, posters, and in other ways it sees fit. I hereby release Omega Psi Phi Fraternity, Inc., its insurer, agents, heirs, successors and assigns from any and all liabilities and claims in connection herewith.

## CONSENT TO TREATMENT/EVIDENCE OF INSURANCE

In the event that my child/ward should for any reason require any minor or surgical treatment and/or medication during the course of his attendance at or participation in the Omega Psi Phi Fraternity, Inc. activities, I authorize such physician or emergency care staff that the Omega Psi Phi Fraternity, Inc. may appoint or designate to carry out the necessary treatment, or to take my child/ward to the emergency room of any hospital, and I further authorize the hospital and its medical staff to provide the treatment deemed necessary by them for the well being of my child/ward. It is understood, however, that if hospitalization or treatment of a more serious nature is required, I will be contacted, if at all possible, by telephone for permission.

I the undersigned, am a parent (or legal guardian) of the above specified child. I have read and fully understand the provisions of the above releases and have explained them to said minor. I further declare that all of the statements that I have made herein are true to the best of my knowledge, information and belief. I hereby agree on behalf of myself and my child/ward to hold harmless and release the Omega Psi Phi Fraternity, Inc., the attending physician(s), hospital, their insurers, agents, heirs, successors, and assigns from any and all liabilities and claims arising out of any treatment rendered to my child/ward.

**PARENT/GUARDIAN SIGNATURE:** ______________________________
**DATE:** ____________________