OKLAHOMA GRAND ASSEMBLY, IORG

**MEDICAL RELEASE AND CONSENT FORM FOR GIRLS**

JURISDICTION: Oklahoma ASSEMBLY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I, the undersigned Parent or Legal Guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“Minor”),

whose birth date is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_; do here by give my consent and permission for her to attend the following activities of the Oklahoma Grand Assembly, International Order of the Rainbow for Girls:

 a. Oklahoma Grand Assembly, to be held at The University of Oklahoma, Norman,

 Oklahoma, on May 27 - 30, 2022.

 b. District Exemplifications / Receptions sponsored by the Oklahoma Grand Assembly.

 c. Supreme Assembly, to be held in Oklahoma City, from July 30, 2022

 through August 3, 2022.

 d. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 In the event of injury or illness to the above named Minor, I, the undersigned Parent or Guardian, hereby authorize any adult Rainbow Advisor in attendance to secure, and any physician in attendance to provide, such emergency medical treatment as shall be deemed necessary by those present; including, but not limited to hospitalization, injections, anesthesia, surgery, x-ray, blood transfusions, and medications. I understand that every reasonable effort shall be made to contact me prior to the administration of any medical treatment.

 The Minor is subject to, or has had, the following medical conditions, illnesses or diseases:

 \_\_\_\_ Measles \_\_\_\_ Appendicitis \_\_\_\_ Sinus Headaches \_\_\_\_ Mumps

 \_\_\_\_ Mononucleosis \_\_\_\_ Frequent Colds \_\_\_\_ Chicken Pox \_\_\_\_ Asthma

 \_\_\_\_ Kidney Problems \_\_\_\_ Pneumonia \_\_\_\_\_Hay Fever \_\_\_\_ Ear Trouble

Please list the Minor’s blood type, if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the Minor wear Contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the Minor allergic to any medications or foods? If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the Minor is presently taking any prescribed medications for **ANY REASON**, please list the

medication and the prescribed dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 The undersigned acknowledges that they are aware and understand that neither the International Order of the Rainbow for Girls, nor the Oklahoma Grand Assembly, maintain any primary medical insurance for its members. I understand that I/we will be responsible for any and all costs of medical treatment incurred by or on behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor. My family health insurance carrier and policy number(s) is/are as follows:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Policy Number Policy Holder’s Name

I, the undersigned Parent or Guardian, **AND** the undersigned Minor do hereby agree that we will abide by the Statutes, Bylaws, rules and regulations of the Supreme Assembly of the International Order of the Rainbow for Girls, and the Oklahoma Grand Assembly. The undersigned Parent or Guardian shall release and hold harmless the Supreme Assembly of The International Order of the Rainbow for Girls, the Oklahoma Grand Assembly, its members, advisors, officers, or sponsoring bodies, from any and all claims, charges, costs, damages or causes of action which the undersigned has or may have arising out of, or in connection with any accident, illness or injury which may occur involving the Minor identified herein as a result of her attendance or participation in any Rainbow sponsored or sanctioned activity or event.

**IN THE EVENT OF AN EMERGENCY AND THE UNDERSIGNED PARENT OR GUARDIAN CANNOT BE REACHED, THE UNDERSIGNED PARENT OR GUARDIAN HEREBY AUTHORIZE THE FOLLOWING PERSON TO ACT ON THEIR BEHALF:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/LEGAL GUARDIAN INFORMATION:**

Your Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street & Mailing Address, if different: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone (H) (\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ Telephone (C) (\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

Relationship to Minor: Parent Legal \_\_\_\_\_ Guardian \_\_\_\_\_ Other (explain) \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature of Parent or Legal Guardian Signature of Minor**

If there are additional factors affecting the medical health of the Minor named herein, or if there is any religious reason that medical cannot be administered to the Minor, please set forth the reasons below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OKLAHOMA GRAND ASSEMBLY, IORG

**MEDICAL RELEASE AND CONSENT FORM FOR ADULTS**

JURISDICTION: Oklahoma ASSEMBLY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, hereby appoint \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

as agent to authorize, in my behalf, emergency medical/surgical treatment, including hospitalization, in the event I am unable to do so and which, in the opinion of any licensed physician, surgeon or hospital, is reasonably required or necessary for my treatment or care. Any physician, surgeon or hospital is authorized to rely upon any authorization for treatment signed by the above designated agent(s) to the same extent as if executed personally by me.

 a. Oklahoma Grand Assembly, to be held at The University of Oklahoma, Norman,

 Oklahoma, on May 27 - 30, 2022.

 b. District Exemplifications / Receptions sponsored by the Oklahoma Grand Assembly.

 c. Supreme Assembly, to be held in Oklahoma City, OK, from July 30 through August 3, 2022

 d. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I am subject to, or has had, the following medical conditions, illnesses or diseases:

 \_\_\_\_ Measles \_\_\_\_ Appendicitis \_\_\_\_ Sinus Headaches \_\_\_\_ Mumps

 \_\_\_\_ Mononucleosis \_\_\_\_ Frequent Colds \_\_\_\_ Chicken Pox \_\_\_\_ Asthma

 \_\_\_\_ Kidney Problems \_\_\_\_ Pneumonia \_\_\_\_\_Hay Fever \_\_\_\_ Ear Trouble

Please list Blood Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does you wear Contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you allergic to any medications or foods? If so, please lis:: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently taking any prescribed medications for **ANY REASON**, please list the

medication and the prescribed dosage:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 The undersigned acknowledges that they are aware and understand that neither the International Order of the Rainbow for Girls, nor the Oklahoma Grand Assembly, maintain any primary medical insurance for its members or adult workers. I understand that I/we will be responsible for any and all costs of medical treatment incurred. My health insurance carrier and policy number(s) is/are as follows:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Policy Number Policy Holder’s Name

I, the undersigned do hereby agree that we will abide by the Statutes, Bylaws, rules and regulations of the Supreme Assembly of the International Order of the Rainbow for Girls, and the Oklahoma Grand Assembly. The undersigned shall release and hold harmless the Supreme Assembly of The International Order of the Rainbow for Girls, the Oklahoma Grand Assembly, its members, advisors, officers, or sponsoring bodies, from any and all claims, charges, costs, damages or causes of action which the undersigned has or may have arising out of, or in connection with any accident, illness or injury which may occur as a result of attendance or participation in any Rainbow sponsored or sanctioned activity or event.

**IN THE EVENT OF AN EMERGENCY HEREBY AUTHORIZE THE FOLLOWING PERSON TO ACT ON MY BEHALF:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMATION:**

Your Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street & Mailing Address, if different: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone (H) (\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ Telephone (C) (\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature**

If there are additional factors affecting the medical health of the person named herein, or if there is any religious reason that medical cannot be administered to said person, please set forth the reasons below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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