

# MEDICAL STATEMENT FOR ALLERGIES



1. YAL Name		2. YAL Telephone Number	
3. Name of Participant		4. Age or Date of Birth	
5. Name of Parent or Guardian		6. Telephone Number	
<p>7. Check One:</p> <p><input type="checkbox"/> Participant has a disability or a medical condition and <i>requires</i> a special meal or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. <b>A licensed physician must sign this form.</b></p> <p><input type="checkbox"/> Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. <b>A licensed physician, physician's assistant, or nurse practitioner must sign this form.</b></p>			
8. Disability or medical condition requiring a special meal or accommodation:			
9. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:			
10. Diet prescription and/or accommodation: <i>(please describe in detail to ensure proper implementation-use extra pages as needed)</i>			
11. Foods to be omitted and substitutions: <i>(please list specific foods to be omitted and suggested substitutions. you may attach a sheet with additional information as needed)</i>			
A. Foods To Be Omitted		B. Suggested Substitutions	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
12. Signature of Preparer*		13. Printed Name	
_____		_____	
14. Telephone Number		15. Date	
_____		_____	
16. Signature of Medical Authority*		17. Printed Name	
_____		_____	
18. Telephone Number		19. Date	
_____		_____	

\* Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form.

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

---

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, and 1400 Independence Avenue, S.W., Washington, DC 20250-9410 or call (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339, or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.





## Sheriff's Youth Activity League Liability Release and Medical Consent Form

Students Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Address/City/Zip: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

I, the undersigned, hereby give permission for the above named minor in my custody to participate in the Sheriff's Youth Activity League and its programs and here by waive, release, and discharge any and all claims or rights for damages in any personal injury and or property damage that may result from the minor's participation of a YAL program. This release is intended to discharge in advance the employees and officials of the Los Angeles County Sheriff's Youth Activity League against any and all liability arising out of or connected in any way with the minor's participation in the activity. I further understand that injuries occasionally occur during the activity and participants in the activity occasionally sustain personal injuries and or property damage, as a consequence thereof. Knowing the risk of the activities, nevertheless, on behalf of the minor, I hereby agree to assume those risk and to release and hold harmless all the persons or entities mentioned above who, through negligence or carelessness, might otherwise be liable to me, my heirs or assigns for damages.

I further understand and agree that this waiver, release and assumption of risk are to be binding on my heirs and assigns. I agree to accept and abide by the rules and regulations of the Sheriff's Youth Activity League and to ensure that my child also abides by the rules and regulations of the program.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

### CONSENT FOR TREATMENT OF MINOR

In the event of sudden illness, accident, or injury which may occur while the above named minor is engaged in the activity supervised by the Sheriff's Youth Activity League and its representatives, employees, agents or assignees, when neither the minor's parent(s), guardian(s) or designated family medical provider can be contacted. I hereby give my consent for emergency treatment as necessary under the circumstances by any medical provider licensed under the laws of the State of California.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

Family Medical Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Minor's medical number: \_\_\_\_\_ Doctor: \_\_\_\_\_

Medical Information: \_\_\_\_\_ Allergies: \_\_\_\_\_

Alternate Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_



## SHERIFF'S YOUTH FOUNDATION PARENTAL AUTHORIZATION FOR RELEASE OF STUDENT RECORDS

The undersigned hereby authorizes \_\_\_\_\_ (school) to release copies of the official student records relating to progress report cards, semester report cards, and school attendance to the Los Angeles County Sheriff's Department and its Sheriff's Youth Foundation. Concerning:

\_\_\_\_\_  
(Full Legal Name of Student)

\_\_\_\_\_  
(Date of Birth)

From 20 \_\_\_\_\_ to 20 \_\_\_\_\_

The reason for this request is to enable the Sheriff's Youth Foundation and the Youth Activities League to capture grade and attendance data related to the above student to support his school-based educational learning with an afterschool tutoring and learning assistance center operated by the Sheriff's Youth Foundation.

My relationship to the child is: \_\_\_\_\_

Copies of the records to be released are to be furnished to:

the undersigned

the student

other (please specify): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone Number: