PHYSICIAN RELEASE FOR MINORS

MEDICAL RELEASE REQUIRED OF PARTICIPANTS WHO WILL BE MINORS AT THE TIME OF THE INTERNATIONAL TRIP DEPARTURE

Dear Health Care Provider:

_____ , a minor, has applied to participate in a local and international service program, Youthlinc. Youthlinc is a Utah based non-profit organization, a 501(c) 3.

This student will be participating in an international volunteer experience and will be traveling to _____ for approximately two weeks in the summer of 20____. Youthlinc international teams include medical professionals who accompany the group, and team members receive an orientation on recommended vaccinations and health concerns in the spring before the summer service experience.

The international experiences associated with the Youthlinc program are not tourist vacations. The student will need to be able to cope physically and mentally with the environment of a developing country, and the unique situations encountered there.

Youthlinc asks each participant who is not of legal age to consult with their Health Care Provider to ensure him/herself and the Youthlinc organization that he/she is able to successfully complete this service experience. Please review the enclosed information, feel free to visit our website www.youthlinc.org, or contact us at 801-467-4417 with any questions.

Applicants not of legal age must have this form signed by their Health Care Provider before acceptance into the program can be finalized.

I've reviewed the above information and considered whether this student has any medical conditions, mental or physical, that would indicate that he/she should not participate in a Youthlinc program as described above. To my knowledge, based only on my examination of this student and the medical records available to me, there are no medical barriers to this individual's participation in a Youthlinc program, subject to any conditions or observations noted below.

_____

Health Care Provider's signature | Health Care Provider's printed name

_____

Date | Area Code | Phone

_____

Street Address | City State Zip

CONDITIONS OR EXCEPTIONS NOTED: PATIENT CONSENT TO DISCLOSE

I consent to the disclosure of the above medical information to Youthlinc and its officers, employees and agents.

Patient signature:_____

Parent/legal guardian signature: _____

PLEASE MAIL THIS FORM TO: YOUTHLINC 1166 E. BRICKYARD RD. SLC, UT 84106

or scan and email to office@youthlinc.org or fax to 801-467-1982