Medical Release and Emergency Contact

Student Information – Please Print

Student's Name:_____Date of Birth ____/_____/_____

Gender: _____M_____F

Home Address:_____

City:_____State:_____Zip:_____

Emergency Notification

Mother:_____Home Phone:_____
Preferred Emergency Contact Daytime Phone /Cell:_____
Father:_____Home Phone:_____
Preferred Emergency Contact Daytime Phone /Cell:_____
Legal Guardian:_____Home Phone:_____
Preferred Emergency Contact Daytime Phone /Cell:_____

Insurance Provider's Information

NOTE: PARTICIPANT MUST HAVE MEDICAL INSURANCE

Provider's Name:_____Provider's Phone No.:_____

Policy Number:_____Insurer's Name:_____

Medical Information

Primary Care Physician:_____Physician's Phone:_____

Special Medical Condition(s):_____

_____

Drug Allergies:_____

_____

Current Medications & Dosages:_____

_____

Special Dietary Needs or Food Allergies: _____

_____

Authorization For Medical Treatment

(The completed form must be on file before treatment is administered.)

I give my permission for such diagnostic, therapeutic, and operative procedures as may be deemed necessary for my son / daughter / ward.

Parent or Legal Guardian's signature is REQUIRED below if the student is less than eighteen years of age.

_____
Signature of Participant Date

_____
Signature of Parent or Legal Guardian Date