MEDICAL INFORMATION FORM AND RELEASE

NOTE: The Release must be signed by the participant's parent/legal guardian if the participant is not of legal age.

As the parent/legal guardian of _____, I request that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment.

PARTICIPANT INFORMATION

Participant's Name _____
Permanent Address _____ Date of Birth_____ Sex_____
City, State, Zip _____ Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to Contact First: Backup Contact (Relative or Friend):
Name _____ Name _____
Relation to Participant _____ Relation to Participant_____
Daytime Phone _____ Daytime Phone_____
Evening Phone _____ Evening Phone_____
Known allergies of this minor, including any allergies to medicine_____
_____
Any other medical problems which should be noted_____
_____
Family Physician_____ Phone_____

INSURANCE POLICY INFORMATION

☐ Yes ☐ No The above-named participant is covered by health insurance.
Policy Holder's Name_____
Policy Holder's Date of Birth_____
Address_____ Relation to Participant_____
City, State, Zip_____ Occupation_____
Policy Holder's Employer's Name_____
Employer Address_____
Insurance Company Name_____
Insurance Company Address_____
Policy #_____ Plan #_____

Signature of Parent/Guardian_____