

# Medical Release Form

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Youth e-mail: \_\_\_\_\_ Parent e-mail: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Phone Numbers:

Work (mom) \_\_\_\_\_ Work (dad) \_\_\_\_\_

Cell (mom) \_\_\_\_\_ Cell (dad) \_\_\_\_\_

## Emergency Contact (other than parent/guardian):

1. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship) \_\_\_\_\_ (Phone #)
2. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship) \_\_\_\_\_ (Phone #)

## Important Medical Information: (If more space is needed, please use the reverse side of this form)

Allergies, dietary, chronic reoccurring conditions, etc...:

Penicillin and/or drug reactions: \_\_\_\_\_ Yes \_\_\_\_\_ No If applicable, please list below:

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Does participant regularly take medication: \_\_\_\_\_ Yes \_\_\_\_\_ No If applicable, please list below:

(only prescription medication in the original container and properly labeled may be administered)

## Insurance Information

Name of Insured: \_\_\_\_\_ Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Co.: \_\_\_\_\_

Phone #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

I, \_\_\_\_\_, give my permission for \_\_\_\_\_ to attend this event with \_\_\_\_\_ and will not hold any organization responsible for any accident that may occur. I also give permission for medical treatment to be administered in case of emergency or illness while traveling under the supervision of the above referenced organization and sponsors. I further grant permission for the organization listed above to send my youth home in the event that their behavior becomes unacceptable as determined by the leadership of the event. I promise to pay the cost of the return trip should this action become necessary.

(signature of parent/guardian)

(date)

(signature of participant)

(date)