Medical Release Form for Youth & Adults

PARTICIPANT INFORMATION:

Name: _____County: _____

Address: _____

Name of Parent or Legal Guardian: (YOUTH ONLY): _____

Primary Physician: _____ Phone: _____

Dentist: _____ Phone: _____

IN CASE OF EMERGENCY:

Primary Contact: _____ Phone: _____

Relationship: _____City: _____ State: _____

Alternate Contact: _____ Phone: _____

Relationship: _____City: _____ State: _____

INSURANCE INFORMATION

Name of Insurance Carrier: _____

Policy Holder Name: _____ Policy #: _____

Date of Last:

Tetanus Shot: _____ Polio Shot: _____ Mumps Shot: _____ Measles Shot: _____Rubella Shot: _____

Medical Information: (check all that apply and explain if necessary)

- ☐ Stomach or Intestinal problems
- ☐ Diabetes or hypoglycemia (low blood sugar)
- ☐ Nervous disorder (convulsions, epilepsy, dizziness, ect)
- ☐ Respiratory problems
- ☐ Heart Disease
- ☐ Any allergies to medication
- ☐ Any allergies to food or plants
- ☐ Special diet or food restrictions
- ☐ Are you currently under a doctor's care?
- ☐ Are you currently taking medications?
- ☐ Are there any physical restrictions or medical problems that may require special considerations?

_____

_____

_____

AUTHORIZATION FOR TREATMENT (YOUTH ONLY)

I, _____ do herby give permission to _____
PARENT/GUARDIAN Name CHAPERONE Name

to seek and obtain any medical care necessary for my child _____ .
YOUTH Participant Name

Parent/Guardian Signature _____ Date _____

ALL PARTICIPANTS

To the Best of my knowledge, accurate information has been provided in all areas of this form.

Participant Signature (youth/ adult) _____ Date _____

IF YOUTH: Parent/Guardian Signature _____ Date _____

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