Medical Information and Release

Medical Insurance Provider: ____________________ Phone number: __________________

Policy Number: ___________________________ Group Number: _____________________

Name of Policy Holder: ____

Current Physician: ________________________ Phone number: ______________________

Emergency Contact: _______________________ Relationship: ________________________

Cell phone: ______________________________ Home Phone: ________________________

Please indicate any medical conditions:

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Physical Limitations:

____

____

List any medications (prescription or OTC) that you take on a regular basis:

____

____

List of Allergies: ____

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Any Food/Diet Restrictions or Allergies:

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In any case of emergency, I give permission to a licensed physician to treat, hospitalize or anesthetize me, or perform surgery on me. I understand that every effort will be made to inform my family and/or emergency contact on my behalf before these actions are taken.

Printed Name: ____

Participant Signature: _____________________________ Date: ______________________

(If the participant is less than 18 years old)

Legal Guardian Signature: ____________________________ Date: ___________________

Relationship to Participant: ____