- MEDICAL RELEASE FORM -

Participant’s Name: ______________________________________ Date of Birth: __________________

Address: ____

Parent/Legal Guardian:____________________________________

EMERGENCY CONTACTS:

Mother: Father:

Daytime phone: ____________________________ Daytime phone: ___________________________

Evening phone: ____________________________ Evening phone: ___________________________

Cell phone: _______________________________ Cell phone: ______________________________

Other: Relationship to Participant: _____________

Daytime phone: ____________________________

Evening phone: ____________________________

Cell phone: _______________________________

MEDICAL INFORMATION:

Medicine(s) in student's possession: ____

My child is allergic to the following foods or medication: ____

List any medical conditions or medical history of which the chaperones should be aware

____

INSURANCE INFORMATION:

Carrier: ___________________________ Group # ________________ Policy Number: _________________

Insured's Name: _______________________ Relationship to Insured: ______________________________

In the event of a medical emergency and a parent or other contact person named above cannot be reached by telephone or otherwise, I authorize Mr. Williams to obtain medical treatment for my child and authorize any physician to examine my child and render such medical and/or surgical treatment which, in such physician's reasonable judgment, may be deemed reasonably necessary for my child's health and safety.

Signature: ____ Date: ____________________

Print Name: ____