Medical Release Form

Parent/Legal Guardian's Name_____

Address: _____

Phone #(s): Home (_____) _____ - _____

Work (_____) _____ - _____

Cell (_____) _____ - _____

Other (_____) _____ - _____

In case of an emergency, please contact: _____

Relationship to Participant: _____

Phone #(s): (_____) _____ - _____ (_____) _____ - _____

(_____) _____ - _____ (_____) _____ - _____

Or Contact: _____

Relationship to Participant: _____

Phone #(s): (_____) _____ - _____ (_____) _____ - _____

(_____) _____ - _____ (_____) _____ - _____

Physician's Name: _____

Address: _____

Phone #(s): (_____) _____ - _____ (_____) _____ - _____

Dentist's Name: _____

Address: _____

Phone #(s): (_____) _____ - _____ (_____) _____ - _____

Participant's Name(s)	List all Known Medical Conditions, Including Food Allergies and/or Drug Allergies. In Addition, Include Any and All Over-the-Counter and/or Prescription Drugs Taken Regularly.

Primary Insurance Company: _____

Phone #(s): (_____) _____ - _____ (_____) _____ - _____

Billing Address: _____

Policy Holder's Name: _____

Address: _____

Relationship to Participant: _____

ID #: _____ Group/Policy #: _____

Secondary Insurance Company: _____

Phone #(s): (_____) _____ - _____ (_____) _____ - _____

Billing Address: _____

Policy Holder's Name: _____

Address: _____

Relationship to Participant: _____

ID #: _____ Group/Policy #: _____

Statement of Consent: (*To be signed in the presence of a legalized notary public*)

In the event of an emergency or non-emergency situation requiring medical treatment, I, _____, hereby grant permission for any and all medical and/or dental attention to be administered to the participant, _____, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Signature: _____ Date: _____

Notarization:

On this _____ day of _____, _____, _____

(Date) (Month) (Year) (Name of Parent/Legal Guardian)

personally appeared before me in _____ County (in the state of _____) and, in my presence, signed this medical release form.

Name of Notary Official: _____

Signature: _____

Commission Expires: _____