MEDICAL FORM

Forms may be filled out by hand or filled out using **Adobe Reader**
(free download at www.adobe.com) then printed and signed.

Personal Information

Name: _____ _____ _____
First *Last* *M.I.*

Gender: ○ Male ○ Female Date of Birth: _____ Phone: _____

Home address: _____ _____ _____ _____
Street Number & Name *City* *State* *Zip Code*

Emergency contact
Name & relationship: _____

Home Phone: _____ Cell Phone: _____

Address: _____ _____ _____ _____
Street Number & Name *City* *State* *Zip Code*

Medical Information

Medications you cannot take: _____

Allergies or health concerns: _____

_____

Medical insurance co._____ Phone: _____

Insurance co. address: _____ _____ _____ _____
Street Number & Name *City* *State* *Zip Code*

Policy holder's name: _____ Group number: _____

Member ID/Policy number: _____

Doctor's name: _____Phone: _____

Address: _____ _____ _____ _____
Street Number & Name *City* *State* *Zip Code*

Medical Release

In the event of an emergency or non-emergency situation in which medical treatment is required, consent/permission is hereby given to **the following persons** (in priority order) to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery (under recommendation of qualified medical personnel):

1: _____ 2: _____
Responsible adult in your group *Alternate responsible adult in your group*

_____ _____ _____
Date *Participant's name printed* *Participant's valid legal signature*

_____ _____ _____
Date *Parent or Guardian's name printed (for minors)* *Parent or Guardian's valid legal signature (for minors)*