

Participant Health Form / Medical Release

This form should be completed in full. It should enable the participant to receive treatment if taken to the hospital by school personnel or a sponsor. One form should be completed for each participant. PLEASE COMPLETE ALL SECTIONS!


I, the undersigned, do hereby authorize officials and sponsors of the to contact directly the person named on this document, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said person. In the event physicians, other persons named on this form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of aforesaid person. I will not hold the school financially responsible for emergency care and/or transportation of said person.

Full Name of participant	
Home Address	Area Code and Phone Number
City, State, Zip Code	
Date of Birth	

Name of Parent, Guardian, or other contact who can be reached if necessary:	Phone Number
Name of Parent, Guardian, or other contact who can be reached if necessary:	Phone Number

Special needs requiring consideration:

Known medical problems:
Allergies:
Prescription and over-the-counter medicines used:
Participant's private physician and physician's phone number:
Insurance information:
Party responsible for payment:
Dietary Requests:

sign here 	Participant or Parent/Guardian, if participant is under the age of 18	Date
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