Medical Release

Name of Team Member ____________________ Date of Birth ____________________

Street Address ____________________ City __________ State ______ Zip ______

Name of Parent/Guardian (If Team Member is a Minor) ____________________ Phone ____________________

Medical and Insurance Information

Family Insurance Company ____________________ Policy # ____________________

Family Physician ____________________ Phone ____________________

Family Dentist ____________________ Phone ____________________

Check all that apply and give appropriate information below:

- ❑ None
- ❑ Allergies
  - ❑ Insects ____________________
  - ❑ Medicines____________________
  - ❑ Other____________________
- ❑ Asthma
- ❑ Bronchitis
- ❑ Diabetes
- ❑ Dizziness
- ❑ Heart Trouble
- ❑ Kidney Trouble
- ❑ Sinusitis
- ❑ Stomach Upset
- ❑ Other ____________________
- ❑ Immunizations
  - ❑ Tetanus: Date received ____________
  - ❑ Hepatitis B: Date received __________

List prescription drugs the team member will be taking while on trip; state frequency and dosage for each.

____

____

Emergency Contact ____________________ Relationship ______________ Phone ______________

Street Address ____________________ City __________ State ______ Zip ______

I ______________________________ of ______________________________

Signature of Parent/Guardian (If Team Member is a Minor) — Team Member

give permission to medical professionals to dispense care in the case of an emergency. I understand that leaders will make every effort to contact designated parent and guardians first.

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