MEDICAL RELEASE FORM

Participant Name:	Participant Date of Birth:
Emergency Contact Name #1:	Phone:
Emergency Contact Name #2:	Phone:
Preferred Physician:	Phone:
Preferred Hospital:	

HEALTH HISTORY – Please fill in the blank and check all that apply:

Allergic to medicine(s): _____
Allergic to food(s): _____
Allergic to stings/bites: _____
Allergic to "other": _____
Diet Restrictions: _____
Vision Impairment/problems other than corrective lenses: _____

Contact Lenses/glasses Chest Pain Concussion or serious head injury Diabetes
Bone or joint problems Shunts Easy bleeding Seizures/Epilepsy
Emotional/Psychiatric/Behavioral problems Non-verbal/alternative form of communication
Requires constant supervision/support Hearing loss/hearing aid Asthma
Heat stroke/heat exhaustion Heart-disease/heart defect High Blood Pressure
Major surgery or serious illness Autism Uses Wheelchair Uses Tabacco
Sickle Cell Trait/Disease Other: _____
Immunizations are up-to-date: Yes No
Date of most recent Tetanus shot: _____

Is the Participant taking any prescription medications:	Yes	No

If yes, please list all medications below:

Medication Name:	Dosage:	Times per day:
1.		
2.		
3.		
4.		
5.		

Signature of person completing this form and relationship to the Participant:

_____ _____
Signature/Printed Name/Relationship Date