

Emergency Medical Release Form

Name: _____
(Last) (First) (MI)

Address _____
(Street) (City) (State) (Zip)

Male Female Age: _____ Phone: (____) _____

Parent's name (If under age 21): _____

Home phone (If different): home- (____) _____ work: (____) _____

Emergency and Health Information (To be completed by all participants):

Do you have: (if "yes" – explain)

Yes No Allergies? _____
 Yes No Heart condition? _____
 Yes No Other? _____

Are you subject to: (if "yes" – explain)

Yes No Fainting? _____
 Yes No Sleep walking? _____
 Yes No Upset stomach? _____
 Yes No Other? _____

Do you have reaction to: (if "yes" – explain)

Yes No Bee sting? _____
 Yes No Penicillin? _____
 Yes No Other drugs? _____
 Yes No Poison Ivy, Oak, Sumac? _____
 Yes No Other? _____
 Yes No Have you had any serious illness or surgery within the past ten years?

Yes No Do you have any condition that would prevent you from participating in any activities?
Please list: _____

Yes No Are you diabetic?
 Yes No Do you have any sight or hearing impairment?
 Yes No Do you wear contact lenses?

Date of last tetanus shot: _____
Please indicate *anything* else that leaders should know to help avoid or deal with any situation that might arise: _____

Emergency information: MUST BE INCLUDED

Health Insurance Co. _____ Policy no. _____

Family doctor's name: _____ work: (____) _____

Emergency contact person: _____ Friend Relative

Address: _____
(Street) (City) (State) (Zip)

Telephone - home: (____) _____ work: (____) _____