MEDICAL RELEASE FORM

Clubber's Name ___________________________________ Birth Date _____________________

Sex _______________ Age________

Parents' Names _______________________ (Mother) ___________________________ (Father)

Address ____ Phone # _______________________

In case of emergency if parents are not available, please notify:

Name ______________________________________ Relationship _________________________

Address ____________________________________ Phone # _____________________________

EMERGENCY TREATMENT AUTHORIZATION

Health Condition _____________________________
Last Tetanus Shot _______________

Name of Physician _________________
Address ____________________________
Phone ______________________________

Preferred Hospital ____
Insurance Company ________________________________ Policy # _______________________
Operations serious injury or illness (include dates).______________________________________
Chronic or recurring illness ____
Under treatment for current illness ____
Medication and instructions of medication being taken __________________________________
Penicillin or other drug reactions ____
Special Remarks (Anything we should know about your child – "e.g. allergies fears etc.".) _____
____

The above information is true to the best of my knowledge. I/We hereby give my/our permission to the doctor and/or hospital to render emergency care or treatment to my/our child named above and authorize my/our child's usual physician to release any information necessary to such care or treatment. I/We will be financially responsible for any and all costs involved. This authorization shall be valid for one (1) year from the date signed. A copy shall be as valid as the original.

Signed _________________________Date ____________________

Signed _________________________Date ____________________