MEDICAL INFORMATION/RELEASE FORM

NOTE: This completed and signed form is required for all participants and due at registration.

Team Name: ______________________________ **Coach's Name:** ____________________________________

State, if USA or Country, if not USA:

____ **Coach's Cell #:**______________________________________

Student's Name: ____ ☐ **Female**

☐ **Male**

Date of Birth: Month______ **Day**______**Year**_________ **Age:**________

Home Address:

____

Number and Street

____

City State Zip Country(if not USA)

Parent/Guardian I Information:

Name: __________________________________ Phone #s: Home: (   )____________________

Work (   )____________________________ Cell (   )___________________________

Email address____

Parent/Guardian II Information:

Name: __________________________________ Phone #s: Home: (   )____________________

Work (   )____________________________ Cell (   )___________________________

Email address____

Family Physician Name: ________________________________Phone #: (   )_______________________

<u>Insurance Information</u> - Primary

Policy Holder's Name _______________________________________

Policy Holder's Date of Birth______________ Relationship to participant_______________

Insurance Company Name____

Policy # ____ Plan #____________________________________

Insurance Company Phone#__________________________________

Address____

Secondary

Policy Holder's Name _______________________________________

Policy Holder's Date of Birth______________ Relationship to participant_______________

Insurance Company Name____

Policy # ____ Plan #____________________________________

Insurance Company Phone#__________________________________

Address____

Continue on back **Over**

Medical History of Participant

List any allergies to medications, animals, foods, dust, chemicals, household items, pollen, bee stings, etc. Indicate how the allergy affects the participant.

Allergic/ Sensitive to: **Reaction:**

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Date of last tetanus vaccine:____________________

Is the participant under the care of a provider for a medical or psychological problem? □ Yes □ No

If yes, please explain:

Is the participant taking any medication? □ Yes □ No If yes, list medicine and purpose.

Medication **Purpose**

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Please indicate any additional information you think we should be aware of:

Permission for treatment of minors: I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for the participant by the medical care facility. I understand that any healthcare facility will make every reasonable attempt to contact me first, time and conditions permitting. I understand I am responsible for charges incurred. I agree that this form will remain in the possession of the team coach, and it will accompany the student to any medical intervention.

Signature of parent or guardian of minor: ______________________________________

Relationship: ________________

Printed Name: ___________________________ Date: ____________________