ADULT

MEDICAL RELEASE AND INFORMATION FORM
(Medical Information For Overnight Trips/Retreats Only)

Name of participant_____ DOB _____

Medication presently on (Name and dosage for each)

_____

_____

_____

Allergies (Foods, Medication, etc.):

_____

_____

_____

Any other Medical conditions (asthma, diabetes, seizures etc)

_____

_____

_____

Date of last tetanus shot _____

Contact Person: (relationship)	Home Phone	Work Phone	Cell Phone
Contact Person (alternate)	Home Phone	Work Phone	Cell Phone

I hereby give my permission to be administered medical help in case of an emergency. If you have medical insurance please indicate the following:

Insurance Company: _____ Phone: _____

Policy Name: _____ Policy Number: _____

Family Doctor: _____ Doctor's Phone Number: _____

signature _____ Date: ___ / ___ / _____

Sworn To and subscribed before me on this _____ day of _____ 20_____

_____
Notary Public (seal)

My commission expires: _____