

**ADULT**  
**MEDICAL RELEASE AND INFORMATION FORM**  
**(Medical Information for Overnight Trips/Retreats Only)**

Name of participant \_\_\_\_\_ DOB \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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 \_\_\_\_\_

<b>Contact Person: (relationship)</b>	Home Phone	Work Phone	Cell Phone
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Contact Person (alternate)	Home Phone	Work Phone	Cell Phone
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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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_