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 _____

_____

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: ___ / ___ / _____