Medical Release Form

Name: _____Date of Birth _____
(Last) (First) (MI)

Permanent Address: _____

_____

Home Phone: ( ) _____ Email:_____

Mother/ Guardian: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____

Father/ Guardian: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____

If my parent is not available, in case of an emergency, please contact:

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

HEALTH HISTORY: (circle/give approximate dates)
Diseases/ Illnesses:

Asthma _____	German measles _____	Mono _____
Bleeding Disorder _____	Heart Problems _____	Mumps _____
Cancer _____	High Blood Pressure _____	Recurring Strep Infect _____
Chicken Pox _____	Hypoglycemia _____	Kidney Problems _____
Diabetes _____	Respiratory Problems _____	Eating Disorders _____
Ear Infections _____	Knee Problems _____	
Measles _____	Other (specify): _____	

ALLERGIES:

Insects _____	Food _____	Other _____

List any previous surgeries or injuries (give dates)

_____

_____

Any illness occurring within the past 5 years that caused you to miss school or work for more than 3 days:

_____

_____

Drug Allergies: (List any medications you are allergic to):

_____

_____

Please list any medical conditions you are currently being treated for:

_____

_____

Please list any medications you are currently taking:

_____

_____

Have you been out of the USA in the past 9 months? If so, where?

_____

In the past 12 months have you been treated for any psychiatric/psychological disorders?

_____

If yes, please explain:

_____

_____

Are you currently being treated for such disorders? Yes ____ No _____

IMMUNIZATIONS:

Tetanus - Date of last shot _____ (please obtain a booster if you are not current)

COVID-19 – Date of last shot _____

I am covered under my parents' Medical Insurance Plan: __ Yes __ No

I have Medical Insurance of my own: __ Yes __ No

Name of Insurance Company: _____

Name of Policy Holder: _____

Policy/Contract Number: _____ Group Number: _____

CONSENT FOR TREATMENT

I hereby give permission to the physician, clinic, or hospital selected for treatment, to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for myself (or my child). **Guardian signature required if under 19 years of age.**

_____ _____

Signature Date

Printed Name: _____