



Medical Release Form *(Approved 1-17-2020)*

Participant's Full Name

Parent/Legal Guardian's Name (Printed) :

Address:

Phone #'s: Home ____-____-____ Cell: ____-____-____ Work: ____-____-____

List all known medical or behavioral conditions – past or present, including food allergies and/or drug allergies.

List all medications, including prescription, over the counter or herbal.

Medical /Behavioral Conditions: (circle and explain all that apply):

Seizures or Neurological Impairment

Any Heart Conditions (murmurs, heart attack, irregular beats, chest pain, high BP, etc.)

Diabetes

Asthma/Respiratory Problems

Vision or Hearing Impairment

Exercise-Induced Problems

Other (include behavioral issues, other medical conditions. need for assistive devices, etc)

MEDICATIONS:

FOOD AND/OR DRUG ALLERGIES:

Emergency Contact: _____

Relationship to participant: _____

Phone #'s: Home ____-____-____ Cell: ____-____-____ Work: ____-____-____

With my signature I acknowledge that this information is correct and current:

Signature: _____ Date: _____