



MEDICAL RELEASE FORM

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Parent, Guardian or Spouse: _____

Name of Emergency Contact: _____

Relationship to you: _____

Phone Numbers: _____

****Please answer all questions and explain below if yes to any question or if you have special instructions we need to know about.**

	Yes	No
1. Take any type of daily medications?	_____	_____
2. Have seizures?	_____	_____
3. Have fainting spells?	_____	_____
4. Have breathing problems?	_____	_____
5. Have any physical impairment?	_____	_____
6. Have eating disorder?	_____	_____
7. Have diabetes or hypoglycemia?	_____	_____
8. Allergic to any foods?	_____	_____
9. Allergic to bee or wasp stings?	_____	_____
10. Allergic to any medications?	_____	_____
11. Any other medical problems?	_____	_____

If yes to any of the above, please explain here:

Insurance Information

Insurance Carrier: _____ Policy Number: _____

Group #: _____ Insurance Contact Number: _____

Physician's Name: _____ Phone: _____

Address, City and State: _____

In the event of an emergency, I authorize medical treatment to be given to me or my child in order to stabilize and protect my or his or her life/health. I understand that every effort will be made to contact the person listed on this form as the emergency contact, however the staff and volunteers for Restoration Hope have the authority to authorize whatever treatment necessary.

Individual's Signature Date

Parent, Guardian or Spouse Date