

Emergency Contact and Medical Release Form

Please fill out this form completely. This document will be kept on file for emergency purposes and authorized medical treatment.

Participant Information

Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Address:

Primary Emergency Contact

Contact Name:

Relationship to Participant:

Primary Phone:

Secondary Phone:

Secondary Emergency Contact

Contact Name:

Relationship to Participant:

Phone Number:

Medical and Insurance Information

Insurance Provider / Carrier:

Policy / Group Number:

Primary Care Physician:

Physician Phone:

Known Allergies (Food, Drug, Environmental):

Current Medical Conditions or Medications:

Medical Release and Authorization

In the event of an emergency, I hereby give permission to the staff and representatives of this organization to secure proper medical treatment, including hospitalization, anesthesia, surgery, or injections, for the participant named above. I understand that every effort will be made to contact the emergency contacts listed above before any major medical decisions are made.

Authorized Signature (Parent/Guardian if under 18):

Date (MM/DD/YYYY):

Printed Name:

