ADULT MEDICAL RELEASE FORM

NAME _____

GENDER _____Male _____Female DATE OF BIRTH _____/_____/_____
MONTH DAY YEAR

ADDRESS _____

CITY/ STATE/ ZIP _____/_____/_____

EMAIL _____ PHONE _____

MEDICAL INSURANCE	**EMERGENCY CONTACT**
INSURANCE COMPANY NAME	NAME
INSURANCE COMPANY ADDRESS	RELATIONSHIP
CITY/ STATE/ ZIP	PHONE
PHONE	
NAME OF INSURED	NAME
POLICY #	RELATIONSHIP
PHYSICIAN NAME/ PHONE #	PHONE

MEDICAL INFORMATION

DATE OF LAST TETANUS _____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN FOR A MEDICAL PROBLEM?
_____ YES _____ NO IF YES, PLEASE EXPLAIN…

_____

_____

ARE YOU CURRENTLY TAKING MEDICATION PRESCRIBED BY A PHYSICIAN?
_____ YES _____ NO IF YES, PLEASE LIST EACH MEDICATION…

_____ _____

_____ _____

_____ _____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?
IF YES, PLEASE EXPLAIN ANY DETAILS UNDER THE CONDITION

CHRONIC HEALTH PROBLEMS? _____ YES _____ NO

_____

_____

ALLERGIES (FOOD, INSECT STINGS, MEDICATIONS, ETC.? _____ YES _____ NO

_____

_____

PROGRAM LIMITATIONS? _____ YES _____ NO

_____

_____

_____

SIGNATURE DATE