

MEDICAL RELEASE & HEALTH BACKGROUND
(Complete one per child)

Date _____

Last Name _____ First Name _____ Middle _____

Address _____

City _____ State _____ Zip _____ Phone _____

Date of Birth _____ Sex Male _____ Female _____

In Case of Emergency: Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Phone _____ (W) _____ (H) _____

Medical Insurance Company _____ Policy # _____

Subscriber's Name _____ SS# _____

If Military – Branch & Duty _____

I hereby authorize any duly authorized doctor, emergency medical technician, hospital, or other medical facility to treat the above named minor for the purpose of attempting to treat or relieve any injuries by said minor while he/she was a participant or observer at an event at the Athletic and Recreation Center at St. Mary's College of Maryland.

I authorize any licensed physician to perform a procedure which he deems advisable in attempting to treat or relieve any injuries or any related unhealthy conditions of said minor that he may encounter during any necessary operation.

I consent to the administration of anesthesia as deemed advisable by any licensed physician. I realize and appreciate that there is a possibility of complications and unforeseen consequences in any medical treatment and I assume any such risk on behalf of myself and said minor. I acknowledge that no warranty is being made as to the results of any treatment.

_____ Date _____

(I have read this release – Sign here)

Relationship to Minor _____

Are all required school immunizations current? _____

Please list any underling medical conditions (allergies, asthma, etc.), current medications, and physical limitations or restrictions.

Physician's Name _____ Phone _____