Medical Information and Release Form

(Please print or type)

Name: _____ Date of Birth _____ Home Phone: _____

Address: _____ Sex: _____
Number & Street City State ZIP

Emergency Info

Emergency Contact: _____ Relation: _____ Phone: _____
Physician's Name: _____ Phone: _____
Who Is Responsible for Medical Payment? ☐ Insurance ☐ Individual
IF INSURED, Medical Insurance Company Name: _____ Phone: _____
Address: _____
Number & Street City State ZIP
Name of Insured: _____ SSN of Insured _____
Preferred Hospital: _____
NOTE: ***Please attach a copy of the insurance card and driver's license of the primary insured person***

Brief Medical History

Special Health Concerns (Allergies, etc.) _____
_____
Allergic to any medications? ☐ Yes ☐ No If yes, please list: _____
Current Medications: _____ Dosage per day: _____
NOTE: ***If you are taking medication regularly, please bring a supply in a labeled container.***

Asthma: ☐ Yes ☐ No Medication: _____
Diabetes: ☐ Yes ☐ No Medication: _____
Epilepsy: ☐ Yes ☐ No Medication: _____
Heart: ☐ Yes ☐ No Medication: _____

Should Activity be restricted? ☐ Yes ☐ No If yes, please explain: _____
Are there any prescription drugs that should NOT be administered? _____

Medical Permission

In the event that I or my underage dependent is involved in an unforeseen catastrophic medical accident, injury or illness, and I am incapable of making, or my dependent is not allowed by law to make, medical decisions regarding treatment, I grant Limited Power Of Attorney to whomever is in charge of the group at the time of the medical emergency. The sole purpose of the Limited Power Of Attorney is so that my, or my dependent's, immediate emergency medical needs may be met. I further agree to assume any and all medical expenses involved in my, or my dependant's, first aid or treatment should such a need arise.

Signature of Member _____ Date _____

Signature (Parent or Guardian if Minor) _____ Date _____

Official Use:
Drivers License: _____ Insurance Card: _____ Reenactors Insurance: _____