MEDICAL RELEASE FORM (ADULTS)

I, ____(Name), hereby give permission for any and all medical attention to be administered to me in the event of accident, injury, sickness, etc. I also assume the responsibility for the payment of any such treatment.

Home Phone ________________Work Phone ___________________Cell Phone________________

Address____

Insurance Company____

Policy Number____

Physician__________________________Phone Number__________________________________

Physician's Address____

Known Allergies____

In case of emergency, please contact the following persons:

Name Relationship Home Phone Work Phone Cell Phone

1.____

2.____

3.____

Signature____ Date__________________________