# **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. This release is effective for the period of one year from the date given below.

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 | Phone |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

| Notes: |
|---|
| |

Signature ______________________ Date ______________________