MEDICAL RELEASE FORM (Adult)

1. _____ (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	Home Phone	Work Phone	Cell Phone
1.					
2.					
3.					

Signature _____ Date _____