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.			

Signature __________________________ Date __________________________