Medical Coverage and Release

Health Coverage Details	
Medical Number:	Do you have private health insurance? yes / no
Insurance Providers Name:	
Policy Holder Name:	Insurance Policy Number:

Doctor's Name:	Phone Number:
Can your doctor be contacted at all times? yes / no	
Dentist's Name:	Phone Number:
Can your dentist be contacted at all times? yes / no	

Emergency Contacts		
First Name:	Last Name:	
Phone: (H)	(W)	(C)
Email:	Relationship:	
First Name:	Last Name:	
Phone: (H)	(W)	(C)
Email:	Relationship:	

Medical Release:

If emergency medical care is required for myself and I or an accompanying spouse or relative am not able to convey permission in a timely manner, then I authorize appropriate emergency medical care as deemed necessary by emergency medical personnel, a physician or the medical facility providing treatment.

Name:	Signature:	Date:

Participant Under 19 Years:

If emergency care is required for my child ______________________________ and if permission is not available in a timely manner, then I authorize appropriate emergency medical care as deemed necessary by emergency medical personnel, a physician or the medical facility providing treatment.

Name:	Signature:	Date:

Medical History Declaration:

To the best of my knowledge, this is a true and accurate description of my/my child's medical history and my/ my child's current condition:

Signed by participant or parent/guardian: ______________________________ Date:______________________