

**INSURANCE AND MEDICAL RELEASE FORM**

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\_\_\_\_\_ (Participant's name) is in good health and can participate in normal activities. Pertinent medical information to be aware of is: \_\_\_\_\_  
\_\_\_\_\_

1. Hospitalization Company Name:

\_\_\_\_\_

2. Policy #:

\_\_\_\_\_

3. Doctor's Name: \_\_\_\_\_

4. Doctor's Address: \_\_\_\_\_

5. Doctor's phone : \_\_\_\_\_

6. Any illness that should be disclosed?

\_\_\_\_\_ Yes \_\_\_\_\_ No    If yes, explain:

\_\_\_\_\_

I authorize the calling of doctor and/or necessary medical services, which I shall pay for, unless covered by insurance.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**If attendee is a minor the parent or guardian must sign**