MEDICAL INFORMATION / RELEASE FOR CARROLLTON YP

Name of Participant_____ Birth date _____ Age____ Sex___

Last, First, Middle

Allergies and/or medical conditions:_____

Medications (incl. dosage) being taken:_____

_____

Name of Physician_____Physician Phone_____

Medical Insurance Company_____Policy Number_____

Parent/Guardian/ Emergency Contact Information

Name of Parent/Guardian_____Relationship_____

Last, First, Middle

Phone Number_____ Email Address_____

Home Address_____

2nd Emergency Contact (Different from above)_____

Name / Relationship / Phone Number

Authorization for Treatment: I/We hereby give permission to Joseph Smith, Mark Hapanowicz, or _____ to secure and administer treatment and to maintain and/or release any medical records necessary for insurance purposes as outlined under the HIPAA regulation, and to provide or arrange necessary related transportation for the above named person.

Signature_____ Date_____