Troy Independent Medical Release Form

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ St\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Information

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies (including medication) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications being taken \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if you have had any of the following in the past FOUR YEARS:

\_\_\_\_\_ Asthma \_\_\_\_\_ Hepatitis

\_\_\_\_\_ Epilepsy \_\_\_\_\_ Bronchitis

\_\_\_\_\_ Stroke \_\_\_\_\_ Heart Attack

\_\_\_\_\_ Angina-chest pain \_\_\_\_\_ Ulcers- stomach/ intestinal

\_\_\_\_\_ Fractures or broken bones \_\_\_\_\_ Fainting/ dizzy spells

\_\_\_\_\_ Diabetes \_\_\_\_\_ Shortness of breath

\_\_\_\_\_ Other (please explain on separate form)

Insurance Company / ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I hereby give my consent for a qualified physician or surgeon to examine, diagnose, prescribe and perform treatment, including surgery, that he deems advisable for the welfare of the above listed patient.

I hereby give consent for the transfer of the member to any hospital reasonably accessible. I understand that no one connected with Starlight Independent, Southern Association for Performance Arts, or Winter Guard International, assumes liability for any injury incurred by the participant. I agree to pay all medical costs incurred by the participant including hospital bills, physician fees, and ambulance fees. I understand that someone in authority will contact the relative listed above at the time they are admitted to the hospital and /or treated by a physician.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If under 18, Please have signed and notarized by your legal guardian)