Adult Medical Release Form

Full Name

Date of Birth

MM/DD/YYYY

Age

Home Address

Phone Number

Emergency Contact Name

Emergency Contact Phone

Primary Physician

Physician Phone

Insurance Provider

Policy Number

List any allergies

List any medications currently taken

Medical conditions or special instructions

Medical Release and Consent

I hereby authorize emergency medical treatment to be administered in the event of accident, injury, or illness, and consent to the release of this information to medical personnel as necessary. I acknowledge that all information provided is accurate to the best of my knowledge.

_____

Signature

_____

Date