



# ADULT MEDICAL RELEASE FORM

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Name \_\_\_\_\_

Date of birth: \_\_\_\_\_ age: \_\_\_\_\_ male/female: \_\_\_\_\_

Home phone # (\_\_\_\_\_) \_\_\_\_\_ mobile phone # (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ work phone # (\_\_\_\_\_) \_\_\_\_\_

Allergies \_\_\_\_\_

Medical History (diabetes, epilepsy, heart murmur, etc)

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

Please list current prescription medications:

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

Date of last tetanus shot \_\_\_\_\_

**Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone # (\_\_\_\_\_) \_\_\_\_\_ mobile phone # (\_\_\_\_\_) \_\_\_\_\_

work phone # (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

**Insurance Information:**

Insurance Company \_\_\_\_\_

Insurance Company's address \_\_\_\_\_