



Information and Medical Release form

(This form must be kept in the vehicle in which you are traveling at all times)

Name _____ Phone _____
Address _____
City _____ State _____ Zip _____
Occupation _____ Birth Date _____

In case of emergency, contact:

Name _____ Relationship _____
Daytime Phone _____ Evening Phone _____
Address _____
City _____ State _____ Zip _____

Name _____ Relationship _____
Daytime Phone _____ Evening Phone _____
Address _____
City _____ State _____ Zip _____

Other relative or responsible person:

Name _____ Relationship _____
Daytime Phone _____ Evening Phone _____
Address _____
City _____ State _____ Zip _____

Medication(s) you can NOT take: _____

Medication(s) you are presently taking _____

(Please send these medications in their original bottle as received from the Pharmacist or Doctor with clearly legible label.)

Allergies/Special health problems or concerns: _____

Insurance Company _____ Phone _____

Address _____

City _____ State _____ Zip _____

Policy# _____ Policy Holder's Identification _____

Doctor's Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Date

Signature of Parent (s) Legal Guardian(s)