

MEDICAL RELEASE FORM

Name of traveler			
Street Address			
City	State	Zip	
Home Phone	Cell Phone		
Emergency Contact #1	Relationship to Traveler		
Primary Phone Number	Secondary Phone Number		
Emergency Contact #2	Relationship to Traveler		
Primary Phone Number	Secondary Phone Number		
Name of Primary Care Physician			
Physician Address			
Physician Phone Number			
Insurance Carrier			
Policy Number			
Billing Address			
Important medical information (allergies - including over the counter medicines, alerts, medicines, prescriptions, etc.)			
School representatives and chaperones are authorized to dispense over-the-counter medications. YES_____ NO_____			
In the event of a medical emergency and if I cannot be contacted, I hereby give permission for my child to receive appropriate medical treatment. I also hereby release school personnel, chaperones, resort personnel, and tour officials from any liability for any actions taken in the normal course of their duties.			
Signature of Parent/Guardian (Primary)			Date
Notary Signature/Seal			Date
Signature of Parent/Guardian (Secondary)			Date
Notary Signature/Seal			Date