CONFIDENTIAL

MEDICAL INFORMATION AND RELEASE FORM

**Copy to be carried by trip leader with original held in confidential file with sponsoring Brevard College Department.*
Complete in blue or black pen.

Form Updated 8.2022
Completed form reviewed by:

Date:

Participant Information:

Participant Full Name:_____ Gender: ☐ Female ☐ Male ☐ Non-Binary

Address: _____ City: _____ State: _____ Zip: _____

Phone#: (_____) _____ ID#:_____ Birthdate: _____

Emergency Contact:

Name: _____ Name: _____

Relation: _____ Relation: _____

Phone #: (_____) _____ Phone #: (_____) _____

Alternate Phone #: (_____) _____ Alternate Phone #: (_____) _____

Medical Information:

Physician Name: _____ Phone #: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Health Insurance Company: _____ Phone # (_____) _____

Name of Policy Holder:_____ Group #:_____ Policy: _____ ID# :_____

Health Issues: List any recent injuries, past serious medical conditions, or conditions under a physician's care. **None** ☐

Allergies: Indicate any allergies, your allergic reactions, and prescribed medications. **None** ☐

Medications Indicate medications (Rx, over the counter, herbal, vitamins, etc.) you are currently taking. **None** ☐

Medication & Dosage	***Condition***	***Carry during trip?***

Additional Medical Health Needs: **None** ☐

Emergency Medical Authorization:

I do hereby authorize Brevard College and its designated representatives to consent, on my behalf, to any medical/hospital care or treatment to be rendered to me upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization. The effective dates of this authorization are from _____ to _____.

Signature: _____ Printed Name:_____ Date:_____

Parent or Legal Guardian, if under age 18):

Signature: _____ Printed Name:_____ Date:_____