MEDICAL RELEASE

Name of Participant _____
First Middle Last

Street Address _____

City, State, ZIP code _____

Date of Birth _____ Phone # _____

Emergency Contact Person _____ Phone # _____

Name of Insurance Company _____ Policy # _____

Please list any medical allergies you have:

_____

_____

Please list any medications being taken:

_____

_____

Please list any medical problems or other pertinent information:

_____

_____

I understand that, in the event medical treatment is required, every effort will be made to notify the emergency contact person. However, if they cannot be reached, I give my permission to Legacy of Healing and any/all of its sponsoring organizations to secure the services of a licensed physician to provide the care necessary, including anesthesia, for my well being.

Signed _____ Date _____

If participant will be under 18 years old at time of travel, a parent or legal guardian's signature is required.