Please email completed form and corresponding documents to Gary@LegacyofHealing.org

Legacy
of Healing

"Only a life lived in the service of others is worth living."

- Albert Einstein

Medical Release Form – PLEASE COMPLETE & SUBMIT ELECTRONICALLY

Applicant Information

Date of Birth: ____________________

Full Name: ________________________________ ________________

Last Name *First Name.*

Address: ____

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Phone Number: __________________________ E-Mail ____

Emergency Contact Name: __________________________ Contact Number: ____

Insurance

Company Name: __________________________ Company Number: ____

Do you have any allergies? YES ☐ NO ☐ If yes, what are they? ____________________

Are you taking any medications? YES ☐ NO ☐ If yes, what are they? ____________________

Are you taking any medications? YES ☐ NO ☐ If yes, what are they? ____________________

Do you have any medical problems? YES ☐ NO ☐ If yes, what are they? ____________________

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Disclaimer and Signature

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 wellbeing.

I certify that my answers are true and complete to the best of my knowledge.

Participant must be 18 years old at time of travel.

Signature: ______________________________ Date: ______________