MEDICAL INFORMATION AND LIABILITY RELEASE

Return to:

Medical Information

First Name _____ Last Name _____ Date _____

Date of Birth _____ Social Security Number _____

Primary Doctor _____ Doctor's Phone _____

Medications _____

Special Dietary Needs _____

Allergies _____

Insurance Information *copy of insurance card is required*

Insurance Company _____ Doctor's Phone _____

Address _____ City _____ State _____ Zip _____

Cardholder _____ Policy Number _____

Emergency Contact Information *must list three*

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Liability Release

I understand that NAME OF ORGANIZATION, does not provide health, accident, or life insurance to participants. I understand that participants/guardians are responsible for providing insurance coverage.

I understand that NAME OF ORGANIZATION, its staff, administrators, funders, and community partners are not liable for any incidents, accidents, or occurrences of Project Everlast participants.

Signature _____ Printed Name _____ Date _____

**If participant is 18 or younger, a Caseworker/Guardian must sign.*