



## Medical Information & Release Form

**Participant Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Gender:** \_\_\_\_\_  
**Description of Activity or Trip:** \_\_\_\_\_ **Program Director:** \_\_\_\_\_  
**Location:** \_\_\_\_\_ **Age of Participant:** \_\_\_\_\_  
**Start Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_

### Emergency Contact

**Primary Emergency Contact Name:** \_\_\_\_\_  
**Email:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Relationship to Person:** \_\_\_\_\_ **Participant Under 18? Is this person a parent or guardian? (Y/N):** \_\_\_\_\_  
**Secondary Emergency Contact Name:** \_\_\_\_\_  
**Phone#:** \_\_\_\_\_

### Medical Information

**Physician Name:** \_\_\_\_\_  
**Phone#:** \_\_\_\_\_  
**Dentist Name:** \_\_\_\_\_  
**Phone#:** \_\_\_\_\_  
**Health Insurance Carrier:** \_\_\_\_\_ **Group#:** \_\_\_\_\_  
**Blood Type:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_  
**Special Health Needs or Concerns:** \_\_\_\_\_ **Date of Last Tetanus/Diphtheria Shot:** \_\_\_\_\_

Current Medications:	Reason for Medication	Authorized to Administer to themselves? (Y/N)	Dosage/Amount

### Emergency Medical Authorization – Adult Participants

I, the undersigned, do hereby authorize Texas Christian University and its designated representatives to consent, on my behalf, to any medical/hospital care or treatment to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered to this authorization. This authorization is effective through the dates listed above. I am eighteen years of age or older, have read the above authorization, and confirm that the information contained therein is true and accurate

\_\_\_\_\_  
*Signature of Participant, if over 18.*

\_\_\_\_\_  
*Date*



**Emergency Medical Authorization – Minor Participants**

I, the undersigned parent or legal guardian of the above-referenced minor participant, do hereby authorize emergency medical or surgical treatment and hospitalization if necessary for the above-named minor. I understand that an attempt will be made to contact me, or the named emergency contact, before taking this action. If I, or the emergency contact, cannot be reached, Texas Christian University and its designated representatives may consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered to the above-named minor participant 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. This authorization is effective through the dates listed above. By signing this authorization, I represent to Texas Christian University that I have legal authority to provide consent for this minor child

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*Signature of Parent or Gurdian,  
if Participant is Under 18.*

*Date*