SPECIALIZED NEEDS RECREATION
MEDICAL RELEASE FORM

Participant Name:_____ Date of Birth:_____Gender (M/F):_____

Parent(s)/Guardian Name:_____Relationship:_____

Parent (s)/Guardian Name:_____Relationship:_____

Participant's Address:_____City:_____State/Country:_____Zip:_____

Home Phone:_____Work Phone:_____Mobile Phone:_____

The parent/guardian section is only required if the participant is a minor or if it applies.

MEDICAL AUTHORIZATION: In case of emergency, if family physician cannot be reached, I hereby authorize myself or my child to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R. Physician)

Family Physician:_____Phone: _____

Address:_____City:_____ST/Country: _____

Hospital Preference:_____

Parent Insurance Co:_____Policy No.:_____Group ID#:_____

SNR Insurance Co:_____Policy No.:_____SNR R/Group ID#:_____

EMERGENCY CONTACTS (IN THE EVENT A PARENT/LEGAL GUARDIAN CAN'T BE REACHED):

Name	Relationship	Phone Number
Name	Relationship	Phone Number
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Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Date of last Tetanus Toxoid Booster: _____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Mr./Mrs./Ms. _____

Participant or Authorized Parent/Guardian Signature Date:

SNR does not limit participation in its activities on the basis of disability, race, color, creed, national origin, gender, sexual preference or religious preference.