PARTICIPANT
Name:_____

Permanent Address: _____

Allergies:_____

Pre-existing Conditions: _____

EMERGENCY CONTACTS
Name:_____

Phone: Daytime_____Cellular_____

Name:_____

Phone: Daytime_____Cellular _____

3$57,&,3$17¶6 5(*8/$5 3+<6,&,$1
Name:_____

Phone:_____

I have read and understand the above Authorization for Medical Treatment: