



MEDICAL RELEASE

Date(s) of Retreat: _____

Participant Information

Name: _____ Sex: _____

Date of Birth: _____ Parent/Guardian's Name (if under 21): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Emergency Contacts

Primary Contact: _____ Relationship to Participant: _____

Daytime Phone: _____ Evening Phone: _____

Secondary Contact: _____ Relationship to Participant: _____

Daytime Phone: _____ Evening Phone: _____

Insurance Policy

Insurance Company: _____

Policy Number: _____ Plan Number: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Participant: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Immunization Dates

Series Completes: _____ Last Tetanus (DPT, YT or TD): _____

Medical History

Does the participant have any of the following? If yes, please explain.

- | | |
|--|--|
| <input type="checkbox"/> Allergies to Insect Bites | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Special Dietary Needs |
| <input type="checkbox"/> Drug Allergies | <input type="checkbox"/> Other Health Problems or Limitation of Activities |
| <input type="checkbox"/> Food Allergies | |

Medications the participant is taking: _____

Will the participant require any specific treatment while participating in our program? Y / N

If yes, please explain: _____

Please note: Our staff cannot administer any medications, prescription or non-prescription, to participants. This includes over-the-counter medicines for minor headaches or pains. If the participant will need medication while attending the retreat, he or she must bring the medication to the retreat and assume responsibility for taking it.

Physician's Information

Physician's Name: _____

Clinic Name/Address: _____ Telephone: _____

Medical Treatment Consent (Parent/Guardian Signature Required)

I consent to examination and treatment of my child by a qualified physician and/or hospital emergency room. I also understand that neither Urban Immersion Service Retreats, nor anyone connected with Urban Immersion Service Retreats will assume any responsibility for accidents or sickness incurred by my child while at their scheduled retreat. I agree to assume sole responsibility for payment of any and all medical, dental, or other expenses incurred as a result of such sickness and/or injury.

Parent/Guardian's Signature: _____ Date: _____

Print Name: _____