

**MEDICAL INFORMATION AND MEDICAL TREATMENT RELEASE AND AUTHORIZATION FORM**

Program Name	_____	Participant Name	_____
Date(s)	_____	Address	_____
Location(s)	_____	City	_____
		State/Zip Code	_____
Parent/Guardian Name	_____	Date of Birth	_____
Telephone	_____	Gender	_____

**Medical Information**

The decision whether to permit the participant identified above (“Participant”) to participate in the program identified above (“Program”) is the sole responsibility of Participant, his/her parent(s) or legal guardian(s), and/or his/her physician(s). The following information will not be used by The University of Tennessee to determine Participant’s ability to participate safely in the Program.

Participant’s Primary Care Physician’s Name and Phone Number: \_\_\_\_\_

Date of Participant’s most recent tetanus toxoid immunization: \_\_\_\_\_

For the following questions, please check a response and explain as appropriate:

<p>Does Participant have any limiting medical conditions that Participant, you, and/or Participant’s doctor believe may limit Program participation? If “yes,” please identify the condition and explain its limiting effect:</p>	<p>YES</p>	<p>NO</p>
<p>Is Participant currently taking any medication that Participant, you, and/or Participant’s doctor believe may interfere with his/her ability to participate safely or effectively in the Program? If “yes,” please identify the medication and explain its potential effect:</p>	<p>YES</p>	<p>NO</p>
<p>Does Participant have a history of allergies or reactions to medications, insect stings, plants, or foods? If “yes,” please explain the history:</p>	<p>YES</p>	<p>NO</p>
<p>Does Participant have a history of, or currently suffer from, any other medical condition(s) of which the Program staff needs to be aware? If “yes,” please identify the medical condition(s) and explain what the Program staff needs to know:</p>	<p>YES</p>	<p>NO</p>

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**Medical Insurance Information**

Policy holder's name \_\_\_\_\_

Policy holder's relationship to Participant \_\_\_\_\_

Policy holder's address \_\_\_\_\_

Please either attach a photocopy of both sides of your insurance card (preferred) or provide the information requested here:

Insurance company name and address \_\_\_\_\_

Insurance company phone number \_\_\_\_\_

Policy numbers \_\_\_\_\_

**Emergency Contact Information**

Participant's Emergency Contact Person \_\_\_\_\_

Primary Telephone Number \_\_\_\_\_

Secondary Telephone Number \_\_\_\_\_

Relationship to Participant \_\_\_\_\_

**Authorization for Medical Treatment**

In the event of an accident or serious injury or illness, I hereby authorize The University of Tennessee and its trustees, officers, employees, agents, and volunteers in official and individual capacities ("Releasees") to obtain medical treatment for Participant. I further agree to accept full responsibility for any and all expenses, including but not limited to medical expenses, that result from, arise out of, or are related to any injuries to my Child that may occur during his/her participation in the Program, Participant's travel to or from the Program, or Participant's presence on premises owned, leased, or operated by Releasees, *INCLUDING BUT NOT LIMITED TO INJURIES SUSTAINED AS A RESULT OF THE NEGLIGENCE OF RELEASEES.*

As Participant's parent or legal guardian, I understand and acknowledge that my failure to disclose relevant information may result in harm to Participant and/or others during this Program. By signing my name I represent and warrant that I have provided all material information to The University of Tennessee pertaining to the medical condition(s) identified above and that it is accurate and complete. I agree to notify The University of Tennessee in writing of any changes in the medical condition of the Participant prior to the start of the Program.

I understand that my disclosure of the medical information above will not be used by The University of Tennessee to determine Participant's ability to participate safely in the Program. I understand that, if Participant participates in the Program, he/she does so voluntarily and of his/her own accord and the final decision regarding participation is solely the responsibility of Participant, me, and/or his/her physician(s).

Signature of Participant's Parent or Legal Guardian \_\_\_\_\_

Printed Name of Participant's Parent or Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_