MEDICAL INFORMATION AND MEDICAL TREATMENT RELEASE AND AUTHORIZATION FORM

Program Name		Participant Name	
Date(s)		Address	
Location(s)	Challenger Center UTC	City	
		State/Zip Code	
Parent/Guardian Name		Date of Birth	
Telephone		Gender	Select one

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:

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:	YES ☐	NO ☐
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:	YES ☐	NO ☐
Does Participant have a history of allergies or reactions to medications, insect stings, plants, or foods? If "yes," please explain the history:	YES ☐	NO ☐
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:	YES ☐	NO ☐

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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 _____