MEN AND WOMEN OF ACTION
MWOA

Medical Release Form

Do you have health insurance? Yes ___ No ___

If yes, name of insurance company: _____

Primary physician: _____

Primary physician phone number: _____

Do you have, or have you ever had any of the following medical conditions?

	Yes	No
Allergies *(if yes, please list allergies below)*		
Asthma		
Diabetes		
Digestive Disorders		

	Yes	No
Epilepsy		
High Blood Pressure		
Heart Condition		
Kidney Condition		

Please list any drug/food allergies: _____

_____

Please state any other medical conditions not mentioned above: _____

_____

Please list any prescribed or over-the-counter medications you are currently taking: _____

_____

IN CASE OF EMERGENCY

Name: _____ *Relationship:* _____

Daytime Phone: _____ *Evening Phone:* _____

I hereby certify that this information is an accurate representation of my medical history. Should any changes occur, I will notify the office immediately. In the event that I need emergency care and am unable to give my consent at that time, I hereby authorize any member of the Men and Women of Action Team to authorize any emergency medical attention that is needed.

Name (printed): _____ Date: _____

Signature: _____

Parent or Guardian Signature (if under age 18): _____

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