

Medical Information Release

REQUIRED FOR ALL PARTICIPATING IN DEAF POWER ORGANIZATION EVENTS

First Name: _____ Last Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Voice Video Relay Serv. (VRS) Text Msg

Work Phone: () _____ Voice Video Relay Serv. (VRS) Text Msg

Birthdate: _____ Age: _____ Female Male

Deaf Hard of Hearing Hearing

Communication Methods (American Sign Language (ASL), Spoken English, Written, ...): _____

Required ASL Interpreter? Yes No

Medical Information:

Do you take any medications? Yes No

If yes, list: _____

Medical Allergies: Yes No

If yes, list: _____

PLEASE NOTE: While you are participating in any event or race, all medications must be kept in their original prescription bottle with name of medication and patient's name on the label.

Describe any other health conditions (if any):

Primary Doctor's Name: (If no doctor, write "none".) _____

Doctor's Phone: () _____

Insurance Co & Policy No. (If no insurance, write "none".)

Emergency Contact Name: _____ Relationship: _____

Day Phone: () _____ Voice Video Relay Serv. (VRS) Text Msg

Night Phone: () _____ Voice Video Relay Serv. (VRS) Text Msg

Pager Email Address: _____

Signature of Participant: _____ Date: _____

Signature of Parent/Guardian*
(If Participant is under 18): _____ Date: _____

*Parent/Guardian is REQUIRED to join the team to be with his/her underage participant.

NOTE: Please place this waiver form in a confidential envelope with your name on it, seal it, and hand it to your team Captain before the event.