Foley Ambassador Program
Medical Release Form

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Mother's Name: _____ Father's Name: _____

Phone Number: _____ Phone Number: _____

Address (if different then above): _____

If unable to reach parents in the case of an emergency:

Please contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

MEDICAL INFORMATION:

Allergies: _____

Medical conditions we should know about: _____

Medications routinely taken by the individual: _____

Individual's physician: _____

Clinic Name: _____ Phone Number: _____

Name of Insurance: _____

Policy Holder: _____

Group #: _____ Policy #: _____

Release for emergency care: In case of an emergency during any event with the ambassadors, I (we) give permission to any member of the Ambassador Program or their volunteers to seek emergency medical treatment for my (our) child. This includes the use of anesthesia should this be necessary.

Signature of Mother: _____ Date: _____

Signature of Father: _____ Date: _____