



**MEDICAL INFORMATION AND RELEASE**

(To be filled out by parent, guardian, or adult participant. Please print in ink.)

**PERSONAL INFORMATION:**

Name: \_\_\_\_\_  
Date of Birth: \_\_/\_\_/\_\_ Age: \_\_\_\_ Sex: \_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_  
Home Number: ( ) - \_\_\_\_\_  
Business Number: ( ) - \_\_\_\_\_  
Cell Number: ( ) - \_\_\_\_\_  
Email Address: \_\_\_\_\_

**IF PERSON ABOVE CANNOT BE REACHED IN THE EVENT OF AN EMERGENCY, NOTIFY:**

First Person: \_\_\_\_\_  
Name: Relationship: \_\_\_\_\_  
Telephone Number: ( ) - \_\_\_\_\_  
Second Person: \_\_\_\_\_  
Name: Relationship: \_\_\_\_\_  
Telephone Number: ( ) - \_\_\_\_\_

**INSURANCE INFORMATION:**

Name of personal physician: \_\_\_\_\_  
Telephone Number: ( ) - \_\_\_\_\_  
Personal health/accident insurance carrier: \_\_\_\_\_  
Policy Number: \_\_\_\_\_

**PLEASE READ AND SIGN:**

I give permission for full participation in Saddleback Archery Club, subject to limitations noted herein.

**In case of emergency**, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin ). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Signature of Parent/Guardian \_\_\_\_\_  
Date: \_\_\_\_\_