

Organization:

Participant
Name:

ISR 17 Medical Insurance Information and Release Form

Please answer the following questions on your present medical history. If you will be swimming or diving at ISR 17, you also need to complete a Diver Medical Questionnaire (available on the ISR Website).

Medical Insurance Carrier: _____

Policy or ID Card Number: _____

List the Following:

Medications Being Taken	Known Drug Allergies

In the event of any accident, illness or disability requiring immediate medical treatment and care, the Participant authorizes:

- The performance of basic emergency first-aid as may be deemed necessary by the ISR staff, and
- The treatment by a physician or medical staff person called by the ISR staff to attend to Participant by examining and performing preliminary transportation of Participant to an emergency room of the local hospital or health care facility if deemed necessary by the ISR staff.
- The release of my medical information to medical personnel for my care.

I, _____ (Participant Name), agree to and authorize any examinations, tests, treatment and medicine deemed necessary by the attending physician and further agrees to pay the cost and expenses of the treatment(s) described above. I authorize the release of this information and all medical information subsequently acquired in association with my participation in ISR 17.

Date _____

Signature

Signature (Participant, or parent(s)/guardian(s) of Participant)