Emergency Medical Release Form

I relieve Cultural Interchanges and the Ladek Zdroj Summer Dance Festival of a responsibility and consequences that may arise as a result of this treatment. I will not he Cultural Interchanges and the Ladek Zdroj Summer Dance Festival or it's administrator and employees liable in the event of any injury. Further, I agree to accept any and all financial responsibility as a result of any necessary medical treatment. The accompanyin health history is correct and complete to my knowledge. Signature	Participan			rat	Middle
In the event of a medical emergency, I give permission to be evaluated, diagnosed, treated and given medication in accordance with standard medical practice by licensed medical personnel. In the event that I cannot consent in an emergency, I hereby give permission to medical personnel to hospitalize, secure treatment, give injections, anesthesia or perform surgery if needed. All medical history information may be shared with appropriate medical personnel in the event of a medical emergency. I relieve Cultural Interchanges and the Ladek Zdroj Summer Dance Festival of a responsibility and consequences that may arise as a result of this treatment. I will not ho Cultural Interchanges and the Ladek Zdroj Summer Dance Festival or it's administrator and employees liable in the event of any injury. Further, I agree to accept any and all financial responsibility as a result of any necessary medical treatment. The accompanyin health history is correct and complete to my knowledge. Signature	Condon.	NA	or F	181	windate
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Participants social security number	health histo	ory is co	orrect and co	omplete to my	knowledge.
Participants social security number In case of emergency, contact: Name	Signature_				date
In case of emergency, contact: Name	Family Ph	ysician			Doctors Phone#
Name	_		_		
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I do have health insurance and the information is below: (If not, you must purchase travel health insurance and provide us with that information) Insurance Company Policy holders name Policy holders social security #					
I do have health insurance and the information is below: (If not, you must purchase travel health insurance and provide us with that information) Insurance Company_ Policy holders name_ Policy holders social security # Relation to participant_ Policy and/or group # Is preauthorization required?Insurance Co Phone #	Home #			work #	cell#
Insurance Company	I do have l	health i	nsurance a	nd the inforn	nation is below:
Policy holders name	(If not, you	must p	urchase trav	vel health insu	rance and provide us with that information)
Policy holders name	Insurance (Compan	ı y		
Relation to participantPolicy and/or group #Insurance Co Phone #	Policy hold	lers nan	ne		
Relation to participantPolicy and/or group #Insurance Co Phone #	Policy hold	lers soc	ial security	#	
Is preauthorization required?Insurance Co Phone #	Relation to	particij	pant		
Did you purchase travel health insurance? If yes please detail below:					
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Drug and Food Al	lergies Current	Current Medications and what for	
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Immunization History		Date Received	
DPT series			
Booster Measles			
Rubella			
Tetanus Test annuali a Test			
Tuberculin Test	• 1 1/1 11		
List any continuing or chro	onic health problems		
List any Physical or learning	no disabilities		
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Medical History: ☐ if you l	nave ever had the following:		
Medical History: [] if you l	nave ever had the following: Hepatitis	High Blood Pressure	
Medical History: [] if you l Headaches Epilepsy/Seizures	nave ever had the following: Hepatitis Gallbladder Disease	High Blood Pressure Thyroid Problems	
Medical History: [] if you l	nave ever had the following: Hepatitis	High Blood Pressure Thyroid Problems Recurrent/Chronic	
Medical History: [] if you l Headaches Epilepsy/Seizures Asthma/Lung Disease	Hepatitis Gallbladder Disease Bladder/Kidney Problems	High Blood Pressure Thyroid Problems Recurrent/Chronic Infectious Diseases	
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