# City of Albany Medical Release

## Youth Participant Information

Full Name: _____ D.O.B. _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

## Primary Parent/Guardian Information

Full Name: _____ Relationship: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Phone:

Cell (_____) _____ - _____ Other (_____) _____ - _____
Home (_____) _____ - _____ Work (_____) _____ - _____

## Secondary Parent/Guardian Information

Full Name: _____ Relationship: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Phone:

Cell (_____) _____ - _____ Other (_____) _____ - _____
Home (_____) _____ - _____ Work (_____) _____ - _____

## Primary Emergency Contact

Full Name: _____ Relationship: _____

Email: _____ Phone: _____

Address: _____

## Secondary Emergency Contact

Full Name: _____ Relationship: _____

Email: _____ Phone: _____

Address: _____

## Physician Contact Information

Physician Name: _____

Email: _____

Address: _____

Phone: _____

## Dentist Contact Information

Dentist Name: _____

Email: _____

Address: _____

Phone: _____

## Primary Medical Insurance Information

Policy Holder's Name: _____ Relationship: _____

*Last* *First* *M.I.*

Member ID: _____ Group/Policy Number: _____

Policy Holder email: _____ Policy Holder Phone: _____

**Billing Address:** _____

*Street Address* *Apartment/Unit #*

_____

*City* *State* *ZIP Code*

**Mailing Address:** _____

*Street Address* *Apartment/Unit #*

_____

*City* *State* *ZIP Code*

## Secondary Medical Insurance Information

Policy Holder's Name: _____ Relationship: _____

*Last* *First* *M.I.*

Member ID: _____ Group/Policy Number: _____

Policy Holder email: _____ Policy Holder Phone: _____

**Billing Address:** _____

*Street Address* *Apartment/Unit #*

_____

*City* *State* *ZIP Code*

**Mailing Address:** _____

*Street Address* *Apartment/Unit #*

_____

*City* *State* *ZIP Code*

## Medications

**Please list any and all over-the-counter and/or prescription drugs:**

## Conditions/Allergies

**List all known medical conditions, including food allergies and/or drug allergies:**

**If there is any other information that Recreation Staff should be aware of, please disclose below.**

## Statement of Consent

*The undersigned do hereby consent to any examination, x-rays, medications, anesthetics, and surgical treatment of the above-mentioned minor that may become necessary based on the recommendations that may be made by the attending physicians. It is understood that this consent is given in advance of any accident or illness that may require diagnosis and treatment, but is given to encourage physicians to use their best judgment and proceed immediately with any necessary treatment. This authorization for diagnosis and treatment is valid only in the event that the undersigned parent or legal guardian cannot be reached in the case of an emergency and shall remain in effect until revoked in writing.*

*In the event of an emergency or non-emergency situation requiring medical treatment, I, _____, hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.*

*Signature:* _____ *Date:* _____