



Medical Information & Release Form A

Name of person attending:

School Grade Completed _____ Sex (circle one) **M** **F** Age _____ Birth date _____

Guardian/Parent/Responsible Person _____

Home Phone _____

Address _____ City _____ St _____ Zip _____

In case of emergency notify: _____ Relationship _____

Emergency phone numbers: Day _____ Night _____ Cell _____

Physician's Name _____ (Imperative if the Participant has allergies.) Phone _____

List any allergies to medications or any known allergies _____

Date of last tetanus immunization _____

List medications presently being taken:

Medical Information & Release Form A cont'd

Medical Insurance
Company_____

Insurance Policy #_____

(This information is needed in case you are unable to provide to the hospital and the guardian/sponsor cannot be reached.)

Participant Signature_____Date_____

AUTHORIZATION FOR EMERGENCY CARE

I/we the undersigned,_____or

Parent/ Legal Guardian/Sponsor of

(name)_____

do hereby authorize any X-ray examination, anesthetic, dental, medical, or surgical diagnosis or treatment by any physician or dentist licensed by the State of Texas and hospital service that may be rendered to said person under the general, specific or special consent of: _____

It is understood that this consent is given in advance of any specific diagnosis or treatment being required,

but is given to encourage those persons who have temporary authority, and said physician or dentist to exercise his/their best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment.

Date_____Parent /Legal Guardian_____

AUTHORIZATION FOR MEDICAL INFORMATION RELEASE

I hereby authorize the hospital to release the following information contained in its hospital records to the representative of the Mingus Job Accelerator concerning Diagnosis, prognosis and treatment for

Name of Participant

Date of birth

Participant Signature_____Date_____

Parent/GuardianSignature_____Date_____