



MEDICAL INFORMATION AND RELEASE FORM – MINOR (DOMESTIC CAMP)

Minor's Name

Address:

City:

State:

Zip:

Telephone Number:

Birthdate:

Gender:

Parent or Guardian Name:

Address:

City:

State:

Zip:

Telephone Number

email:

Emergency Contact Name (other than parent or guardian):

Address:

City, State Zip:

Telephone Number:

email:

Physician Name:

Dentist Name:

Telephone Number:

Telephone Number:

Allergies:

Blood Type:

Current Medications and dosage:

Date of Last Tetanus/Diphtheria Vaccinations:

Special Health Needs or Concerns:

Health Insurance Carrier Name:

Phone Number

Policy Holder Name:

Policy Holder Date of Birth

Policy Number:

ID Number:

EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned parent or legal guardian of _____ do hereby authorize emergency medical or surgical treatment and hospitalization if necessary for the above named minor. I understand that an attempt will be made to contact me, or the named emergency contact, before taking this action. If I or the emergency contact, cannot be reached, the Championship Mock Trial Academy and its designated representatives may consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered to _____ upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization. The effective dates for this authorization are **July 13, 2025** through **July 20, 2025**.

By signing this authorization, I represent to the Championship Mock Trial Academy that I have legal authority to provide consent for this minor child.

Signature of Parent or Guardian

Date