

Future Problem Solving Program International Conference 2018

Medical Information/Release Form

Participant Information

Last Name _____ First Name _____
Street Address _____ Date of Birth _____ Male ___ Female ___
City, State, Zip _____ Phone _____

Event Information

International Conference 2018; University of Wisconsin La Crosse June 6-10, 2018

Medical Emergency Contact Information

Person to Contact First Name _____	Back-up Contact (Friend or Relative): Name _____
Relation to Participant _____	Relation to Participant _____
Daytime Phone _____	Daytime Phone _____
Evening Phone _____	Evening Phone _____

INSURANCE POLICY INFORMATION

Yes No The above-named participant is covered by health insurance.
(If yes, provide the following information, which is required to expedite treatment and to facilitate the billing process.)

Policy Holder's (PH) Name _____	PH's Date of Birth _____
Address _____	Relation to Participant _____
City, State, Zip _____	Occupation _____
PH's Employer _____	Employer Address _____
Insurance Co. Name _____	Insurance Co. Phone _____
Policy # _____	Plan # _____

PARTICIPANT ALLERGIES AND/OR MEDICATIONS

List any allergies participant has and how the allergy affects the participant.

List any current medications and purpose of medications taken by the participant.

PARENTAL PERMISSION

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter by any cooperating medical facility. I understand that any health care facility will make every reasonable effort to contact me first, time and conditions permitting. I understand I am responsible for charges incurred. I have read and understand this form and have had an opportunity to ask any questions about it.

Printed Name _____ Signature _____
Relationship _____ Date _____