Future Problem Solving Program International Conference 2019

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 2019; University of Massachusetts Amherst June 5-9, 2019

Medical Emergency Contact Information

Person to Contact First:
Name _____
Relation to Participant _____
Daytime Phone _____
Evening Phone _____

Back-up Contact (Friend or Relative):
Name _____
Relation to Participant _____
Daytime 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 _____
Address _____
City, State, Zip _____
PH's Employer _____
Insurance Co. Name _____
Policy # _____

PH's Date of Birth _____
Relation to Participant _____
Occupation _____
Employer Address _____
Insurance Co. Phone _____
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 _____