Chappaquiddick Community Center, Inc. Medical Information & Consent Form

CIRCLE PROGRAM(S):	Tennis Saili	ng	TTOR
PARTICIPANT (printed):		SEX	XD.O.B
Address on Chappy:			
Please check those that apply (Provide necessary det	tails below):		
Chronic Ailments	Allergies		
Asthma/Respiratory Problems	Medication		
Diabetes or Hypoglycemia	Bee Stings/Insect bites		
Hemophilia/Other bleeding problems	Foods		
Circulatory/Heart Problems	Others		
Epilepsy			
DETAILS:			
under circumstances where I am physically unable to consent of the furnishing to myse and treatment by any hospital, physician or physicians 2. I authorize any officer of the Community Center to community C	elf, my spouse or any of my s may deem necessary or a consent to such medical care, attention or treatment and an amounty Center and its official examination, anesthetic ber of the medical staff or at operating certificate issumosis, treatment or hospital physician in the exercise of gned prior to rendering treatments.	ndvisable. e, attention nd to inden icers, direct , medical of a dentis and by the of a care being of his/her b	n or treatment. nnify and hold free and harmless of etors and employees. or surgical diagnosis or procedure st licensed in the Commonwealth of Commonwealth. It is understood g required, but is given to provide the process of the provide the process of the provide the process of the provide the provided the pr
NAME	RELATIONSHIP	PHO	NE
NAME	RELATIONSHIP	PHO	NE
SIGNATURE OF PARENT OR GUARDIAN		DAT	E

INSURANCE ID. #

HEALTH INSURANCE COMPANY