UNCA Medical Authorization Form

Participant Information

NAME _____

ADDRESS _____

DATE OF BIRTH _____

MEDICAL AUTHORIZATION

I authorize the faculty leader to give necessary hospital or medical facility permission for the above named person on my behalf if an emergency demands it and time prevents my direct participation.

The above-named individual is covered by the following health and accident insurance which provides coverage while living in the United States.

Company Name _____

Policy Number _____

Please list any known allergies (medical, food, or otherwise):

Please list medications that you regularly take:

Please indicate any medications that you should ***not*** take:

Please indicate any other special medical needs or problems:

List the address and telephone number for two persons who can be contacted in case of emergency:

1) _____

2) _____

Please provide any additional pertinent medical information:

_____ _____

Witness Participant's Signature

_____

Date

We honor the principles in the Americans With Disabilities Act and welcome participation of all individuals with disabilities.