MEDICAL INFORMATION FORM

***Name of Participant*: _____**

Parent/Guardian Print Name: _____

Relationship to Participant: _____

Parent/Guardian Signature: _____

Home#: _____ Cell#: _____

Name of Doctor: _____

Phone#: _____

Insurance Carrier: _____

Insurance #: _____

Preferred Hospital: _____

****Please note in the space below if the participant has any significant health conditions or concerns Project Graduation volunteers should be aware of (dietary needs, allergies, epilepsy, diabetes, medications needed during the event, ect.) Please list any medical condition(s), medication(s), and instructions needed (continue on back side if necessary):**