

Medical Emergency Release Form

This information is requested as a precaution in the event a mishap would occur and F.I.T. staff are unable to contact a responsible party.

Fencer's Name: _____

CONSENT FOR MEDICAL TREATMENT

This is to certify that on this date I, _____, give my consent to the Fencing Institute of Texas and its representative to obtain medical care from any licensed physician, hospital or clinic for the above named athlete for any injury or illness that may arise during while participating in Fencing Institute of Texas programs or on Team trips.

(Signature of Fencer)

(Date)

(Signature of Parent or Guardian of Minor)

(Date)

INSURANCE INFORMATION:

	Primary Insurance Information	Secondary Insurance Information
Name of Carrier		
Name of Policy Holder		
Address of Carrier		
Policy Number		

List any known allergies to food or drugs: _____

Limiting physical conditions (e.g., asthma): _____

Current medications: _____

Other information for emergency or medical staff: _____

In the event of emergency, contact: _____

Relationship to athlete: _____ Telephone: _____

Other person(s) to contact: _____

Relationship to athlete: _____ Telephone: _____