Acton Recreation
Medical Form

Participant Name:_____

DOB:_____ Age:_____ Gender: M/F

Insurance Carrier:_____

Policy #:_____Group #:_____

Family Physician:_____Phone:_____

Hospital of choice for second transport if deemed necessary by Goodall Hospital:
:_____

Allergies (ie bee stings, peanuts etc.): _____
_____

Allergies to Medications: Y/N

List Medical Conditions (ie glasses, asthma, braces etc.)._____
_____

Emergency Contacts

1) Parent/Guardian first and last name:_____
   Home Phone:_____Cellphone:_____Work Phone:_____

2) If Parent/Guardian is unavailable:_____
   Relationship to Participant:_____
   Home Phone:_____Cellphone:_____Work Phone:_____

If I cannot be reached in an emergency, I hereby consent for a qualified physician or surgeon to examine, diagnose and to prescribe or perform treatment, including surgery, that is deemed advisable for the welfare of the named above participant. I further understand all risks to my child while involved in sports activities and will not hold Acton Recreation or its agents responsible for any possible injury resulting from their participation in Acton Recreation activities.

I understand this informed consent form and agree to its conditions on behalf of my child/self.

_____ _____
Parent/Guardian Date

PLEASE RETURN FORM WITH REGISTRATION TO THE ACTON TOWN HALL.