MEDICAL INFORMATION AND RELEASE
FLORIDA INSTITUTE OF TECHNOLOGY
MINOR OR ADULT PARTICIPANT

(PLEASE COMPLETE FORM IN BLUE OR BLACK INK)

NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

DATE OF BIRTH: _____
(MO.) (DAY) (YEAR)

HEALTH/ACCIDENT INSURANCE CARRIER: _____

POLICY NO.: _____ GROUP NO.: _____

PERSONAL PHYSICIAN: _____

PHYSICIAN'S ADDRESS: _____
(STREET) (ITY) (STATE) (ZIP CODE)

PHYSICIAN'S PHONE NUMBER: _____
(AREA CODE) (NUMBER)

PARENT, LEGAL GUARDIAN, OR OTHER PERSON WHO HAS LEGAL AUTHORITY TO AUTHORIZE MEDICAL TREATMENT TO PARTICIPANT IN CASE OF EMERGENCY. PLEASE CONTACT:

NAME _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP CODE)

HOME TEL: _____ WORK TEL: _____ CELL TEL: _____
(AREA CODE) (NUMBER) (AREA CODE) (NUMBER) (AREA CODE) (NUMBER)

Please list any chronic or acute medical problems (Continue on back if needed): _____

_____

Please explain: _____

_____

List any allergies to food, pollen or medicine: _____

_____

List any medications being taken at present: _____

_____

I ACKNOWLEDGE THE PARTICIPANT'S IMMUNIZATIONS ARE CURRENT: _____YES _____NO

I or MY CHILD plan to attend a FLORIDA INSTITUTE OF TECHNOLOGY CAMP, hereinafter referred to as "CAMP." I fully realize that injury or illness could result from or during MY or MY CHILD'S participation in the CAMP. In case of accident or illness, I give my permission to receive medical treatment as deemed appropriate. I will assume responsibility for any medical bills.

_____
ADULT PARTICIPANT or PARENT/LEGAL GUARDIAN'S SIGNATURE

PLEASE PRINT CAMP PARTICIPANT NAME: _____

IF MINOR, PLEASE PRINT PARENT'S NAME: _____

REV. 9.18.2008