University of Dayton
Medical Release Form

(Please Print Information)

Participant Information:	
Last Name:	
First Name:	
Middle Initial:	
Age:	
Home Address:	
City/State/Zip/Country:	
Parent or Guardian Information	
Name:	
Home Phone:	
Work Phone:	
Cell Phone:	
Medical Information: Please circle YES or NO, give details for YES response.	
Do you have any allergies (including medications)?	YES NO
Are you presently taking any medications (if so, please list)?	YES NO
Do you have any significant health problems (if so, please list)?	
Physician's Name & Phone:	
Any additional information or special circumstances?	

I authorize the staff of the University of Dayton Student Health Center and/or any other medical facility designated by the UD Student Health Center to provide necessary medical services for treatment of illness or injury, including diagnostic procedures such as laboratory tests and x-rays to:

Name of Participant

Title of University of Dayton Program **Dates of Program**

I understand that I will be notified in case of serious illness or injury, or if surgical treatment is necessary.

Signature of Parent or Guardian **Date**