

ISU Medical Information Form And Release and Waiver of Liability

NOTE: The Release and Waiver of Liability must be signed by the participant's legal guardian if the participant is not of legal age.

PARTICIPANT INFORMATION

Participant's Name _____

Permanent Address _____

City, State, Zip _____

Date of Birth _____ Sex ____

Home Phone () _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to Contact First:

Name _____

Relation to Participant _____

Daytime Phone () _____

Evening Phone () _____

Backup Contact (Relative or Friend):

Name _____

Relation to Participant _____

Daytime Phone () _____

Evening Phone () _____

Are you allergic to any medications? _____

List current prescriptions/medications _____

INSURANCE POLICY INFORMATION

Yes No The above-named participant is covered by health insurance.

If yes, provide the following information which is required by Iowa State University to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name _____ P.H.'s Date of Birth _____

Address _____ Relation to Participant _____

City, State, Zip _____ Occupation _____

P.H.'s Employer's Name _____

Employer Address _____

Insurance Company Name _____

Insurance Company Address _____

Policy # _____

Plan # _____