

**PROJECT DISCOVERY MEDICAL RELEASE FORM**

**All Information is Strictly Confidential**

Name of participant: \_\_\_\_\_ SS# \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

**Medical Information:**

Does your child have any of the illnesses, diseases, or conditions?

Diabetes type 1 \_\_\_\_\_ Diabetes type 2 \_\_\_\_\_ Asthma \_\_\_\_\_ Epilepsy \_\_\_\_\_

Sickle Cell Anemia \_\_\_\_\_ Heart disease \_\_\_\_\_ HIV \_\_\_\_\_ AIDS \_\_\_\_\_ Depression \_\_\_\_\_

Attention Deficit \_\_\_\_\_ Hyperactivity Disorder \_\_\_\_\_

Other: Please specify \_\_\_\_\_

Is your child taking any medication for any of the above conditions? If so, please list them:

\_\_\_\_\_, \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_

Is your child allergic to any known medication or food? If so, please list them:

\_\_\_\_\_  
\_\_\_\_\_

In case of emergency, does Project Discovery have your permission to take your child to a hospital or medical facility to receive treatment? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please provide insurance information: Name, Address, Policy Number and other relevant information regarding your insurance company.

\_\_\_\_\_  
\_\_\_\_\_

In case of emergency, list person to notify:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Day \_\_\_\_\_ evening \_\_\_\_\_

Cell \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature:

\_\_\_\_\_  
Date