BLUE KNIGHTS MEDICAL INFORMATION AND RELEASE

MEMBER'S NAME _____ _____ _____
Last First Middle

ADDRESS _____E-MAIL_____

CITY/STATE/ZIP_____

PHONE ( ) _____ BIRTH DATE _____ AGE _____

DOCTOR'S NAME _____ PHONE ( ) _____

HAVE YOU EVER SUFFERED FROM THE FOLLOWING:

_____ DIABETES _____ SKIN DISEASE _____ HEPATITIS
_____ EPILEPSY _____ VARICOSE VEINS _____ PNEUMONIA
_____ HEAD INJURIES _____ HERNIA _____ KIDNEY TROUBLE
_____ SPECIAL DIETS _____ ARTHRITIS _____ STOMACH TROUBLE
_____ TUBERCULOSIS _____ HEART TROUBLE _____ EYE PROBLEMS
_____ EAR PROBLEMS _____ FAINTING OR BLACKOUTS
_____ NERVOUS OR MENTAL DISORDERS _____ BLOOD PRESSURE PROBLEMS
_____ FRACTURES Where?_____
_____ ALLERGIES: _____

Do you suffer from any medical condition other than the ones listed above? Please describe: _____
_____

Can you take aspirin? YES NO Can you swim?_____

Are you currently taking medication? Please describe:_____

INSURANCE COMPANY_____POLICY NUMBER_____

EMPLOYER (if applicable)_____ID NUMBER_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____

HOME NUMBER ( )_____ WORK NUMBER ( )_____

RELATIONSHIP TO MEMBER_____

In any emergency that endangers the health of the above named member, permission is hereby granted for the proper medical attention to be administered. I authorize the management of the Blue Knights to act in my behalf and release from liability those adults and medical personnel who may treat and/or authorize treatment for my child while traveling with the Blue Knights.

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Member Signature Date

Subscribed to me and sworn before me this _____(date) of _____, _____

_____ My commission expires _____
Notary Public Date Seal