

MEDICAL INFORMATION AND RELEASE
2012 PREMIER FLIGHT ACADEMY
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 Number: _____ Group Number: _____

Personal Physician: _____

Physician's Address: _____
(Street) (City) (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: _____ Work: _____ Cell: _____
(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 Premier Flight Academy Youth 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 permission to receive medical treatment as deemed appropriate. I will assume responsibility for any medical bills.

Adult Participant or Parent/Legal Guardian's Signature (Date)

Please Print Camp Participant Name: _____

If Minor, Please Print Parent's Name: _____