



# Medical Release Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

City: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

State/Zip Code: \_\_\_\_\_

Parent's Name: Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Parent's Work: Father: \_\_\_\_\_ Mother: \_\_\_\_\_

## Medical Insurance Information

Insurance Company: \_\_\_\_\_

Insurance Company Mailing Address: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Policy Number/Group Number: \_\_\_\_\_

Physician's Name & Phone #: \_\_\_\_\_

Dentist's Name & Phone #: \_\_\_\_\_

## Medical History Information

Operations or Serious Injuries (dates): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Chronic or Recurring Illnesses: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

Allergies to medications or insect stings: \_\_\_\_\_

\_\_\_\_\_

Special diet: \_\_\_\_\_

Special medication (name it) and how it is given: \_\_\_\_\_

\_\_\_\_\_

Activity restrictions: \_\_\_\_\_

## **Inoculation Information**

Vaccinations that are not required, but highly recommended for South Africa are: Hepatitis A, Hepatitis B, Malaria, Rabies, Typhus/Typhoid, Tetanus-diphtheria, Measles, and Polio. For further questions, consult your physician, or visit the Center for Disease Control at [www.cdc.gov](http://www.cdc.gov).

List dates of shots:

Hepatitis A: \_\_\_\_\_

Hepatitis B: \_\_\_\_\_

Typhus/Typhoid: \_\_\_\_\_

Tetanus (highly recommended): \_\_\_\_\_

I certify that the above statements are true and correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_