

Rhythmic Force Medical Release

Member Name _____ DOB _____
(Last Name) (First Name) (MI)

Sex: M F

Permanent Address _____ Phone: Home _____ Cell _____

A. Emergency Contact Information

Father's Name _____ Phone: Day _____ Evening _____

Mother's Name _____ Phone: Day _____ Evening _____

Emergency Contact, in case parents cannot be reached:

Name _____ Address _____ Phone _____

B. Authorization to Treat

In case of illness or injury to the above named RF member, and in the event that I cannot be contacted, I hereby authorize a representative of Rhythmic Force to secure appropriate emergency medical services.

Date _____ Member (if 18 or over) or Parent/Guardian's Signature _____

C. Medical Insurance Information

Physician _____ Phone _____

Insurance Company Name and Address _____

Policy Holder's Name _____ Policy No. _____

D. Medical History

Are you currently taking medication? Yes No

If yes, please list the medication(s): _____

Pertinent Medical History _____

Known Allergies (medical or other) _____

Date _____ Member (if 18 or over) or Parent/Guardian's Signature _____