UNIFIED RECREATION TRIP MEDICAL RELEASE 2024

Please Attach a Current Photo of the Participant!

PERSONAL INFORMATION

Participant Name: ______________________________ Age: ____________ DOB: ________

Residential Address: ______________________________ City: ____________ State: ______ Zip: ______

Home Phone: ______________ * Cell: ____________________ Work: ____________________

*Email: ____

Gender: ________ Hair Color: ________ Eye Color: ________ Height: ________ Weight: ________

Specific/Identified Disabilities: ____

Participant/Guardian Signature: ______________________________ Date: ______________

PARENT/GUARDIAN INFORMATION

Guardian Name: ______________________________ *Contact Phone: ______________

Guardian Address: ______________________________ City: ____________ State: ______ Zip: ______

*Email: ____

EMERGENCY CONTACT (IF DIFFERENT FROM PARENT/GUARDIAN)

Name: ______________________________ *Contact Phone: ______________

Address: ______________________________ City: ____________ State: ______ Zip: ______

*Email: ____

INSURANCE INFORMATION

Medicare: ________________ Medicaid: ________________ Other: ________________

Physician: ______________________________ Phone: ______________________

Physician Address: ______________________________ City: ____________ State: ______ Zip: ______

*ATTACHMENTS

Please attach Medication Administration Record (MAR) or an original prescription label and current list of medications

Please attach any additional information that you think might assist the Unified Recreation Staff.

*** Required Information**

COMPLETE INFORMATION ON BACK →

MEDICAL/MEDICATION INFORMATION

Medications Taken (if any)	Dosage	Times	Purpose
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________

Does the participant need assistance with medications? YES ☐ NO ☐

If yes, please explain: ____

Is the participant diabetic? YES ☐ NO ☐ ☐ Sugar-free dessert ☐ Smaller portion dessert ☐ Regular portion dessert

Does the participant need assistance handling money? YES ☐ NO ☐

If yes, please explain: ____

Does the participant have or use any of the following (please check):

	NO	YES	EXPLAIN:
Seizures			
Dietary Needs			
Hearing Aids			
Corrective Eyewear			
Toileting Needs			
Showering Needs			
Communication Devices			
Orthopedic or Prosthetic Devices			
Fears/Phobias			
Manual Wheelchair			
Power Wheelchair			
Walking Cane			
Cigarettes/Pipe/Tobacco			
Elopement Issues			
Down Syndrome			

If YES to Down Syndrome, has the participant been tested for atlantoaxial subluxation**?** YES ☐ NO ☐

If YES, were the results positive or negative? POSITIVE ☐ NEGATIVE ☐

Does the Participant Communicate?	NO	YES	EXPLAIN:
Verbally			
By Sign Language			
By Writing			