CK Travels MEDICAL RELEASE FORM 2019-2020

I, _____ (Parent/Guardian or Spouse's Name) hereby give permission for any and all medical attention to be administered to _____ (patient's name) in the event of accident, injury, sickness, including blood transfusion, surgery, dental treatment, mental health care, etc., under the direction of **Michael D. Fultz**, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period July 9th, 2020 to July 20th, 2020 and/or while the above person (patient) is travelling as a member of a CK Travels Tour Group.

INSURANCE COMP: _____

POLICY NUMBER: _____

PHYSICIAN NAME: _____

PHYSICIAN ADDRESS: _____

PHYSICIAN PHONE: _____

KNOWN ALLERGIES: _____

CURRENT MEDICATION: _____ Dosage: _____

CURRENT MEDICATION: _____ Dosage: _____

CURRENT MEDICATION: _____ Dosage: _____

BLOOD TYPE: _____

PATIENT WEIGHT: _____

PATIENT BIRTHDATE: _____

SIGNATURE OF PARENT/GUARDIAN OR SPOUSE:

_____

DATE: _____

TURN OVER 

Parent / Guardian or Spouse Contact Information

Mother's or Spouse's Name : _____

Father's or Spouse's Name: _____

Family's Physical Street Address: _____

City: _____

State:_____ Zip code_____

Home Phone Number: _____

Home Fax Number:_____

Mother's or Spouse's Cell Phone:_____

Father's or Spouse's Cell Phone:_____

Mother's or Spouse's Business Address: _____

Fax Number:_____

Father's or Spouse's Business Address: _____

Fax Number:_____

Additional Emergency Contact in the United States: _____

Home phone Number of Additional Emergency Contact: _____

Cell of Emergency Contact: _____

Medical history that you wish us to know:_____

_____

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Revised: 10/14/2019