Counselor Medical Release Form

Name: _____ Date of Birth: _____ Gender (M/F) _____

Address: _____City: _____ State _____ Zip_____

Home Phone: _____Mobile Phone: _____

Email: _____

COUNSELOR AUTHORIZATION
In case of emergency, if family physician cannot be reached, I hereby authorize myself to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R. Physician)

Family Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Hospital Preference: _____

Insurance Co: _____ Policy No: _____ Group ID#_____

If physician cannot be reached in case of emergency contact:

_____ _____ _____
Name Phone Relationship

_____ _____ _____
Name Phone Relationship

☐ Please check if you take NO medications

Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder

Allergies:_____

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Date of last Tetanus Toxoid Booster: _____
The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

_____
Authorized Counselor Signature **Date**