

Release of Health/Medical Information

For emergency purposes, please complete and return this form to the State Pageant Director. The information will help us to provide the best care for all contestants. All information will be kept confidential.

Contestant's Name: _____

Parents' Full Name: _____ Phone: _____

Doctor's Name: _____ Phone: _____

Insurance Company: _____ Group #: _____

Other contacted person if above can't be reached:

Name: _____ Phone: _____

Name: _____ Phone: _____

Medical/History/Problems: (check if you have these problems):

___ Asthma ___ Diabetes ___ Heart Disease ___ Nose Bleeds ___ Seizures

Allergies: _____

Other Conditions: _____

Special Instructions: _____

List any medications taken and special instructions: _____

I, _____ am responsible to have and keep health/medical information available at all times. All medical claims made by me (the contestant) are my responsibility, and I agree that GAD/Miss Deaf Georgia Pageant are waived of any liability.

Signature of Contestant

Date

Signature of Parent/Guardian (if under 18)

Date

State Pageant Director

Date