Purdue Intercollegiate Bowling Program
Medical Information and Treatment Authorization

Participant

Name: _____

Address: _____

_____

Phone: _____

Emergency Contacts (Please list in preferred order of contact)

Name: _____

Address: _____

_____

Phone: Home_____ Office_____

Relationship to Participant:_____

Name: _____

Address: _____

_____

Phone: Home_____ Office_____

Relationship to Participant:_____

Physical Restrictions:_____

_____

_____

Medical Restrictions (such as asthma or diabetes):_____

_____

_____

Medications Currently Taken :_____

_____

_____

Known Allergies(pollen, bee stings, milk):_____

_____

Dietary Restrictions:_____

_____

Please list here any additional information you believe to be relevant:_____

_____

In the event of illness or injury, should I be unable to direct my own medical care, I hereby authorize any of the activity coordinators or instructors to seek medical care on my behalf. This includes, but is not limited to, medical transport, hospitalization and testing, surgery and prescription drugs deemed advisable for my condition.

_____ _____

Participant's Signature Date
