BAY VIEW COMMUNITY CENTER
1320 E. Oklahoma Ave.
Milwaukee, WI 53207

Adult Medical Release Form

(Must be on file before participant attends class- Please print)

PROGRAM_____ PROGRAM DATES_____

PARTICIPANT NAME_____ PHONE_____

ADDRESS_____CITY_____ZIP_____

MEDICAL PROBLEMS AND/OR OTHER PERTINENT HEALTH INFORMATION:_____

_____

INSURANCE INFORMATION

DOCTOR'S NAME & EMERGENCY TELEPHONE NUMBER:_____

INSURANCE COMPANY & POLICY NUMBER:_____

HOSPITAL/CLINIC:_____

EMERGENCY CONTACT: NAME:_____

ADDRESS(IF DIFFERENT THAN ABOVE):_____

PHONE:_____ RELATION:_____

In consideration of your acceptance of the registration for the above named program I hereby release Bay View Community Center and any of its collaborative institutions, all sponsors and contributors, and any other entities who are in any way connected with Bay View Community Center or its collaborative agencies/institutions or this program/activity (including volunteers) and their successors and assigns from any and all liability or claim for any damage, injury or illness which I may suffer arising out of or related to my participation in this program or activity.

This release applies to me, my personal representatives, heirs and assigns. I consent to emergency treatment in the event of illness or accident. I grant permission to the Bay View Community Center to use any photograph or any other record of this event for any legitimate purpose. I acknowledge that I have read and fully understand my own liability and do accept the restrictions indicated above.

Date_____ Signature_____