LOS ALAMOS

MINOR PARTICIPANT
EMERGENCY CONTACT AND MEDICAL RELEASE FORM

Name of Minor Participant: ______________________________ **Date of Birth:** ________________________

Name of Parent or Legal Guardian: ____

Address: ____
Street Address *City* *State* *Zip*

Home phone: _______________ **Business Phone:** ____________________ **Cell Phone:** ___________________

Emergency Contacts/Authorized Pick-Ups: (required)
Please list other possible individuals who may be contacted in case of emergency if you are not available, and whether or not they are authorized to pick up the minor. Please note, any person not listed below WILL NOT be permitted to pick up the minor without written permission from a parent or legal guardian.

Name	Phone	Pick-Up?	Relationship to Minor
1.		YES / NO	
2.		YES / NO	
3.		YES / NO	

Medical Conditions/Allergies: (required)
If the minor has any condition that may require special treatment it is imperative that a medical provider is alerted. Please indicate below any on-going medical or emotional problems that may require special attention (e.g., epilepsy, allergies, asthma, disability, anxiety, depression, etc.) including medications currently taken. Use reverse side if necessary.

Medical Condition(s):	Medication/Dosage:	With Minor?
		YES / NO
		YES / NO
		YES / NO
Allergies:	**Describe reaction:**	**Severity?**
		LOW/MED/HIGH
		LOW/MED/HIGH

Primary Care Physician's Name: ______________________________ **Phone:** ___________________________

Health Insurance Company Name: ____________________________ **Policy Number:** ____________________

I verify that all the information provided is correct and complete. I realize that participation involves an inherent potential risk. In the event of an emergency, I authorize the University of New Mexico ("UNM") and its agents or representatives to make arrangements as reasonably necessary to ensure my child's welfare. In the event of an emergency, permission is granted to UNM to authorize emergency transportation, emergency medical care and/or treatments and hospital care for the minor. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

____________________________________ ____________________________________ ______________
Signature of Parent/Legal Guardian Print Parent/Legal Guardian Name Date