University of Delaware Model United Nations Conference

Release and Student Medical Information Form

Participant Name: ____

Last First Middle

Home Address: ____

Number/Street City State ZIP

Sex: M F **Birth Date**: __________/ ______________/ ________________

WAIVER of CLAIM / RELEASE FORM: This certifies that we, the undersigned, in consideration of the benefits to be derived by our above-named son/daughter (Participant), do certify that he/she may participate in any normal and routine training session or meeting of the University of Delaware Conference, and hereby release University of Delaware Model United Nations and University of Delaware from any and claims resulting from an illness, injury or accident incurred or suffered by said son/daughter while traveling to, attending, or participating in the Conference.

MEDICAL and HOSPITAL SERVICES CONSENT: This certifies that we, the undersigned parents/guardians, in the event that our above-named son/daughter (Participant) becomes a participating member of the University of Delaware Model United Nations Conference, do hereby consent and grant permission, should the necessity arise, for the furnishing of medical treatment and hospital services as ordered and recommended by a qualified physician, including the administration of an anesthetic, laboratory procedures, medical or surgical treatment, x-ray examination, or other hospital services. Consent is hereby granted to the attending physician(s), hospital(s), and/or clinic(s) to release necessary medical information to our local doctors and for use in claims for insurance coverage.

WAIVER of PHYSICAL EXAMINIATION STATEMENT: This certifies that we, the undersigned parents/guardians understand our responsibility to fully inform the University of Delaware and Conference staff of any and all medical precautions and to provide, attached hereto, any and all medical records or information for use and reference by local physicians or medical personnel should the need arise.

Participant's Physician: ___________________ **Doctor's Phone No.**: (______) ______________

INSURANCE INFORMATION:

The Participant is covered by health insurance: Yes No

Insurance Company: ___________________________ **Policy Number**: _____________________

Primary Card Holder's Name: _____________________________

EMERGENCY CONTACT INFORMATION: Please provide information on where you can be reached 24 hours a day in the event of an emergency.

Parent/Guardian 1: ________________ **Emergency Phone No.:** __ (______) _________________

Parent/Guardian 2: ________________ **Emergency Phone No.:** __ (______) _________________

AUTHORIZED SIGNATURES: I/We certify that the information contained in this form is true and correct:

Parent/Guardian Signature and Date: ____________________________ _____ /_____ /_____

Parent/Guardian Signature and Date (Optional): ___________________ _____ /_____ /_____