2008 WIND Clinic

"Creating Future Generations of Champions"

Student Medical Release

Please print, fill out, sign and return this form to;

***WIND* Registrar**
CGRA
P O Box 19175
Portland, OR 97280

Participant's Name_____

Participant's #-mail Address_____

Address: _____

City:_____State: _____

Zip Code_____ Tel: ( ) _____

Family Physician: _____ Insurance Co:_____

Policy Number:_____Tel: ( )_____

Have you been treated for:

Rheumatic Fever □ Heart Disease □ Chronic Disease of the Lung □

Asthma □ Chronic Ear Disease □ Disease of the bones or joints □

Epilepsy □ Any vision or hearing defect □ Do you wear Contact Lenses ? ___

Last Physical Examination: _____

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special provisions of the Medical Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding license to operate for the State of Oregon Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or Hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the Patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Signed:_____ Date: _____
(If over 21 participant. If under 21, Mother, Father or Legal Guardian)

In case of Emergency, Please Notify: Name:_____

0r _____ **Tel/Cel:** _____