EAGLES WINGS TRACK CLUB

Medical Release Information

Athlete: _____

Primary Insurance Coverage: _____

D.O.B.: _____ M/F: _____

Group/Policy Number: _____

Family Physician: _____

Phone: _____

In Case of Emergency

Contact Name: _____ Phone: _____

Relationship: _____

Please list any allergies/medical conditions that could affect your athlete's participation in training: (i.e. Asthma, Seizures, Heart Conditions, etc.)

Medical Conditions: _____

_____

Medications: _____

Parent/Guardian Signature:

_____ Date: _____