

HEADQUARTERS
CIVIL AIR PATROL
UNITED STATES AIR FORCE AUXILIARY
8550 LLOYD STEARMAN DR., SUITE 118
NEW ORLEANS, LOUISIANA 70126-8034

MEDICAL RELEASE FORM

NAME _____ CAPSN _____ CHARTER _____
(LAST NAME, FIRST NAME, MI)

EYE COLOR _____ HAIR COLOR _____ HEIGHT _____ WEIGHT _____

ADDRESS _____ CITY _____ STATE _____

ZIP CODE _____ HOME TELEPHONE _____ DOB _____

PARENTS WORK PHONE _____ EXTENSION _____

NEAREST RELATIVE _____ PHONE _____

NEAREST NEIGHBOR _____ PHONE _____

FAMILY DOCTOR _____ PHONE _____

MEDICAL INSURANCE PLAN _____

GROUP NUMBER _____ CONTRACT NUMBER _____

BLOOD TYPE _____

MEDICATIONS ALLERGIC TO _____

MEDICATIONS CURRENTLY TAKING _____

ANY OTHER PERTINENT INFORMATION YOU WOULD CONSIDER IMPORTANT

I, _____

() being the parent(s) of the above described person

() being the legal guardian of the above described person

hereby give full authorization to any Medical Doctor, Medical Clinic and/or Hospital to administer emergency medical services to the above described person. This authorization is only valid on Civil Air Patrol activities.

SIGNED _____ DATE _____