



Beautiful Feet International Permission for Medical Treatment Form

Name: _____

Address: _____

Date of Birth: _____

In emergency, notify: _____

Phone: _____ Relationship: _____

Physician Name: _____ Phone: _____

Family Insurance: _____

Policy# _____

Tetanus Date: _____ Other Immunizations _____

Past Medical History

Asthma _____ Sinusitis _____ Kidney Trouble _____ Heart Trouble _____ Bronchitis _____

Diabetes _____ Dizziness _____ Stomach upset _____ Hay Fever _____ Other _____

Explain Other: _____

ALLERGIES

Previous operations or serious illness _____

All Current Medications _____

Special Diet (be specific) _____

Permission for Treatment and Discharge: My permission is granted for those associated with this trip to obtain necessary medical attention in case of sickness or injury for _____ I do release, and forever discharge all sponsors from any and all claims, demands, actions or cause of action, past, present, or future arising out of any damage or inquiry while participating in the event.

Signature (Parent, if traveler is a minor): _____

_____ Date: _____