Medical Waiver Form PDF

Name of Patient: _____

Date of Birth: _____ **(MM/DD/YYYY)**

Address: _____

Contact Number: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Medical Condition(s): _____

Current Medications: _____

Allergies (if any): _____

Waiver Statement:

I, the undersigned, hereby give my consent to receive medical treatment deemed necessary in the event of an accident, injury, or illness during my involvement in activities. I understand the risks involved and agree to waive all claims against the institution or organization.

Signature of Patient: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

Please check the appropriate box:

- **I have read and understood the medical waiver form.**
- **I require further clarification on the waiver details.**