



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: _____