

**UNIVERSITY OF DAYTON CHEERLEADING
MEDICAL RELEASE**

Last Name First Name Age

Street Address

City State Zip

Parent or Guardian Home Phone Work Phone

Do you have any allergies (including medications)? _____ Yes _____ No

If so, list: _____

Are you presently taking any medication? _____ Yes _____ No

If so, list: _____

Do you have any significant health problems? _____ Yes _____ No

If so, list: _____

Physician's Name Physician's Phone

Any additional information (special circumstances, cell/pager numbers, etc.):

I authorize the University of Dayton athletic trainer, a member of the athletic trainer's staff, the staff of the University of Dayton Student Health Center and/or any other medical facility designated by said persons to provide necessary medical services for treatment of illness or injury, including diagnostic procedures such as laboratory tests and x-rays to

Name of Participant

I understand that I will be notified in case of serious illness or injury, or if surgical treatment is necessary:

Signature of Parent or Guardian Date