

LOUISIANA WING  
CIVIL AIR PATROL  
UNITED STATES AIR FORCE AUXILIARY  
4514 BLANCHE NOYES AVENUE  
BATON ROUGE, LOUISIANA 70807

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 \_\_\_\_\_