

CISA Medical Release

Please fill out, print, sign and return this form to:

Marylee Goyan
PO Box 180580
Coronado, CA 92178

Place cursor over line to fill out form

Participant's Name: _____

Participant's E-Mail Address: _____

Family Physician: _____

Address: _____

City, State, Zip: _____

Tel: (____) _____

Insurance Co.: _____ Policy Number: _____

Have you been treated for:

Rheumatic fever Heart disease Chronic disease of the lung

Asthma Chronic ear disease Disease of the bones of joints

Epilepsy Other: _____

Any vision or hearing defect _____

Do you wear contact lenses? Yes No

Last Physical Examination:

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff licensed under the provisions of the Medical Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of

California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Signed: _____ Date: _____

(if over 21) Signature of Participant

(if under 21) Signature of Father, Mother or Guardian

In Case of Emergency, Please Notify:

Name: _____ Tel: (____) _____

Name: _____ Tel: (____) _____