



Summit Music Festival

270 WASHINGTON AVENUE, PLEASANTVILLE, N.Y. 10570 • TEL 914.747.2020 • FAX 917.261.4684
www.summitmusicfestival.org • info@summitmusicfestival.org

MEDICAL RELEASE FORM

PARTICIPANTS 18 YEARS AND OVER AS OF 7/29/17

Name _____
LAST FIRST MIDDLE

Address _____

City _____ State _____ Zip _____ Country _____

Telephone Number _____ Alternate Number _____

Birth date ____/____/____ Age ____ Gender: Male Female

Emergency Contact Information

Name _____ Name _____

Relation _____ Relation _____

Phone _____ Phone _____

Alternate Phone _____ Alternate Phone _____

Medical Information

Allergies _____

Medication(s) you are taking (including dosage) _____

Date of last Tetanus/Diphtheria Inoculations _____ Blood Type A+ O+ B+ AB+ A- O- B- AB-

Physician Information

Name _____ Phone - Office _____

Address _____ Phone - Emergency _____

Do you have health insurance? Yes No Insurance Company _____ Phone _____

Group # _____ Policy# _____ I.D.# _____

Special Health Needs or Concerns _____

Emergency Medical Authorization

I, the undersigned, do hereby authorize Summit Music Festival and its designated representatives to consent, on my behalf, to any medical/hospital care or treatment to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization of treatment rendered pursuant to this authorization. The effective dates for this authorization are July 29 through August 13, 2017.

I am eighteen years of age or older, have read the above authorization and confirm that the information contained therein is true and accurate.

Signature of Participant _____ Date _____