UNIFIED RECREATION
Medical Release Form 2026

Please Attach Current Photo

PERSONAL INFORMATION

Participant Name: _____ Age: _____ DOB: _____

Residential Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ *Cell: _____

*Email: _____

Hair Color: _____ Eye Color: _____ Height: _____ Weight: _____

Guardian Signature: _____ Date: _____

PARENT/GUARDIAN INFORMATION

Guardian Name: _____ Contact Phone: _____

Guardian Address: _____ City: _____ State: _____ Zip: _____

Email: _____

EMERGENCY CONTACT *(if different from parent/guardian)*

Guardian Name: _____ Contact Phone: _____

Guardian Address: _____ City: _____ State: _____ Zip: _____

Email: _____

MEDICAL/MEDICATION INFORMATION

Medications Taken (if any)	Dosage	Times	Purpose

Does the Participant Need Assistance with Medications? Yes ____ No ____

If Yes, Please Explain: _____

Is this Participant Diabetic? Yes: ____ No: ____ Sugar-Free Dessert: _____ Smaller-Portion: _____ Regular Portion: _____

Any Special Dietary Needs? _____

Does the Participant Have/Use Any of the Following?

	No	Yes	Explain
Seizures			
Hearing Aid			
Corrective Eyewear			
Toileting Needs			
Showering Needs			
Fears/Phobias			
Elopement Issues			

MOBILITY INFORMATION

Is the Participant Ambulatory? Yes: _____ No: _____

Does the Participant Use a Wheelchair? Yes: _____ No: _____

Other Assistive Devices Used for Ambulation? Yes: _____ No: _____

Able to Use Stairs? Yes: _____ No: _____

Needs to Use Lift on Bus? Yes: _____ No: _____

Comments:

_____

_____

FOOD RESTRICTIONS

Does Participant Need Assistance with Meals? Yes: _____ No: _____

If Yes, Please Explain:

_____

_____

_____

Gluten Free: ____ Dairy Free: ____ Diabetic/Low Sugar: ____ Other: ____

Comments:

_____

_____

_____

ALLERGIES

Tree Nut: ____ Peanut: ____ Seasonal: ____ Other: ____

Comments:

_____

_____

_____

COMMUNICATION

Does Participant Use Sign Language: Yes: _____ No: _____

Can Participant Read & Write: Yes: _____ No: _____

Does Participant Need Assistance Handling Money: Yes: _____ No: _____

SAFTEY

Willing to Stay with Group: Yes: _____ No: _____

Able to Say Name & Phone Number: Yes: _____ No: _____

Can Manage Own Money: Yes: _____ No: _____

Can Keep Track of Their Belongings: Yes: _____ No: _____

Can Recognize Danger: Yes: _____ No: _____

Will Wander or Run Away: Yes: _____ No: _____

ATTACHMENTS

Please attach Medication Administration Record (MAR) or an original prescription label and current list of medications
Please attach any additional information that you think might assist the Unified Recreation Staff

*** Required Information**