Pacific Crest Trail Association
Emergency Medical Release for Minors

This form is required for participation by minors in Pacific Crest Trail Association sponsored activities.
Please complete each section thoroughly, sign and date.

Minor's Name: _____ _____
Last First

Sex: F ☐ M ☐ Decline to answer ☐ Age: _____ Birthdate (MM/DD/YY): _____

Parent/Guardian Name: _____ Relationship: _____ Home Phone #: (____) _____

Cell Phone # : (____) _____ Work Phone # : (____) _____ Email address: _____

Additional person(s) authorized to pick up the above named minor and/or to contact in case of an illness or emergency:

Name: _____ Relationship: _____ Phone # : (____) _____

Name: _____ Relationship: _____ Phone # : (____) _____

Allergies: Does the minor have any allergies to food, medications, insects, etc.? ☐ Yes ☐ No

If Yes, please list: _____

Health Conditions: Has the minor, currently or in the past, been diagnosed with any of the following health conditions (check all that apply):

Asthma	☐ Yes ☐ No	Epilepsy/Seizure Disorder	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Frequent Migraine Headaches	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Attention Deficit-Hyperactivity	☐ Yes ☐ No
Vision/Hearing Problems	☐ Yes ☐ No	Chronic Ear Infections	☐ Yes ☐ No

If Yes, please explain: _____

List any other health condition(s) not listed above: _____

List any medication(s) currently taken by the minor: _____

Name of minor's Physician: _____ Physician's Phone #: _____

Name of Insurance Company: _____ Policy/Medical#: _____

In case of emergency, the minor will be taken to the nearest medical/dental facility.

Emergency Release

If, in the judgment of the Pacific Crest Trail Association, the above named minor needs immediate care and treatment as a result of any injury or sickness, and I, or other authorized person, cannot be reached, I hereby give permission to secure proper treatment for the minor at the nearest medical/dental facility. I do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services. It is understood that a good faith attempt 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. It is further understood that the undersigned will assume full responsibility for any such action, including payment of costs. I do hereby agree to indemnify and hold harmless the Pacific Crest Trail Association (including its officers, directors, members and/or volunteers) from any claim by any person whomsoever on account of such care and treatment of said minor.

_____ _____ _____
Print Full Name of Parent/Guardian Signature Date