SUMMER TRIP 2016

ADULT PARTICIPANT HEALTH STATEMENT

All medical information will remain confidential and used only by permission of the participant. Please complete and sign this Health Statement form and mail it to FBA along with a copy of the participant's insurance card to: Forever Bloom Alliance, Inc, 6927 SW 115 Place, Suite A-38, Miami, Florida, 33173

1. Participant's Name: _____ Age: _____

   Telephone: Home_____ Work_____ Cell_____

2. Contact person (1) in case of an emergency:

   Name: _____ Relationship: _____

   Telephone: Home_____ Work_____ Cell_____

3. Contact person (2) in case of an emergency:

   Name: _____ Relationship: _____

   Telephone: Home_____ Work_____ Cell_____

4. Physician's Name: _____

   Telephone: _____

   Medical History: If applicable, complete the following:

a. I have the following disability and/or medical problem: _____

   _____

b. I have the following allergies: _____

   _____

c. I am unable to participate in the following physical activities: _____

   _____

d. I am currently on the following medications:_____

   _____

I fully authorize medical treatment for myself in case of accident or illness while on the trip.

Signature: _____ Date: _____