



UNIFIED RECREATION
Trip Medical Release Form 2025
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: _____

Explain:

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: _____

SAFETY

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

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

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

Recognize Danger: Yes: _____ No: _____

Can Manage Own Money: Yes: _____ No: _____

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