MEDICAL FORM
FOR ADULT/SENIORS PROGRAMS

RECREATION SERVICES

PERSONAL INFORMATION			
Last Name	**First Name**	**Today's Date**	
Address	**City**	**State**	**Zip**
E-mail Address		**Birth Month/Day**	
Home Phone	**Cell Phone**	**Male/Female**	

MEDICAL INFORMATION	
Physician Name	**Physician Phone Number**
Medical Conditions or Allergies:	
Medications:	

NEAREST RELATIVE or EMERGENCY CONTACT		
Name	**Relationship**	**Phone #**
Name	**Relationship**	**Phone #**

Medical Release/Waiver of Liability Agreement

Should a medical emergency arise, we will attempt to notify the nearest relative or emergency contact. If the undersigned is unavailable for consultation, permission is granted for the City of Orinda and/or Town of Moraga staff to obtain medical treatment as deemed necessary. I, the undersigned, do hereby consent to any examinations, x-rays, medications and anesthetics and surgical treatments that may be rendered based on the recommendation that may be made by the physicians on duty.

I, the undersigned, in consideration of the diversity of the senior recreation programs and activities, understand that there is an inherent risk of injury in some programs in which I may participate in and in further consideration of legal representations and assigns to defend, indemnify, and hold harmless the City of Orinda and/or Town of Moraga, its officers, employees or agents from and against any and all claims, liabilities, losses, damages, cost of expenses, and release Orinda and Moraga, its officers, employees, agents and volunteers from any and all liability for any injury, conduct of its members, damages, or inconveniences which may be suffered by the above named individual arising from, or in any connected with my participation.

Signature: _____ Date: _____