NAVAL RESERVE OFFICERS TRAINING CORPS
(NROTC)
STANDARD RELEASE FORM

I, ________________________________(print name), a member of the Naval Reserve Officers Training Corps Battalion, University of Wisconsin, in consideration of sponsored extracurricular activities, to wit Physical Fitness Training and do hereby release from any and all claims, demands, actions, or causes of action, due to death, injury, or illness, the government of the United States and all its officers, representatives, and agents acting officially and also the local, regional, and national Navy Officials of the United States.

I hereby authorize personnel of the Department of Defense, Armed Forces, Public Health Service, or civilian physicians to render such medical and dental care as may be necessary and medically indicated in my case during this period of activity, as is deemed necessary by a qualified practitioner. (If student is under 18, parental consent is required. Please see bottom of form).

I understand that care at a military medical facility for non-military dependents will normally be rendered on a temporary (emergency) basis only; if further care is indicated, the patient will be transferred to non-military care as soon as possible. Emergency care provided to midshipmen who are not military dependents at a military medical facility may be subject to reimbursement, and I may be billed for the care provided. For Navy Medical Department facilities, such care is authorized by NAVMEDCOMINST 6320.3B.

I have no known medical conditions that might preclude or limit in any way my participation in the above mentioned activities.

I have a current medical/dental insurance policy as follows:

Medical Insurance Company *

Name of Medical Insurance Company: ____

Address of Medical Insurance Company: ____

Telephone of Medical Insurance Company: (   ) ____________________________________

Policy/ID Number: ____

Telephone Confirmation Number: (   ) ____

Dental Insurance Company *

Name of Dental Insurance Company: ____

Address of Dental Insurance Company: ____

Telephone of Dental Insurance Company: (   ) _____________________________________

Policy/ID Number: ____

Telephone Confirmation Number: (   ) ____

* This insurance is not required. However, the information provided may be required to obtain non-emergency care.

I have the following known allergies:

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I am taking the following medications or treatment:

Student's Signature: ____
Date

Student's Printed Name: ____
Date

Address: ____

Telephone: (   ) ____

Age of Student: ____

If under 18, a parent or legal guardian must sign.

_________________________________ _________________________________
SIGNATURE OF PARENT SIGNATURE OF PARENT Date

_________________________________ _________________________________
TYPED/PRINTED PARENT NAME TYPED/PRINTED PARENT NAME Date