

MEDICAL EMERGENCY FORM

Name of Child _____ Date of Birth _____

SS# _____ Address _____

IN CASE OF EMERGENCY, NOTIFY:

Name _____ Relationship: _____ Parent _____ Other _____

Address _____

City _____ State _____ Zip Code _____

Telephone Numbers: Home: (____) _____ Work: (____) _____

ALLERGIES (Please write YES if applicable)

Hay fever _____ Asthma _____ Sulfa _____ Poison Ivy _____

Penicillin _____ Bee Sting _____ Other _____

PLEASE CHECK IF CHILD HAS ANY OF THE FOLLOWING CONDITIONS:

Diabetes _____ Convulsions _____ Bleeding Disorders _____ Contact Lenses _____

Fainting Spells _____ Heart Trouble _____ Prosthesis _____ Migraine Headaches _____

If any of the above are YES, please submit statement of how the child has been treated and with what medication.

PLEASE CHECK APPROPRIATE RESPONSE:

YES _____ NO _____ My child can be given aspirin or tylenol if needed for minor pain.

YES _____ NO _____ My child has a medical condition. If yes, please describe: _____

YES _____ NO _____ My child is taking medication. If so, please list name, dosage and medical condition: _____

YES _____ NO _____ Treatment received for any illness/injury within the last year? If yes, please explain: _____

In case of emergency, I understand that no effort may be made to contact parents or guardian prior to emergency treatment. I hereby give permission to any physician, hospital and/or health care personnel to secure proper treatment for, hospitalize, and to order injections, medication, anesthesia, surgery or other necessary treatment for my child named above. I also give permission to secure proper emergency medical transportation.

HEALTH INSURANCE CO. _____ POLICY NO. _____

FAMILY PHYSICIAN _____ FAMILY PHYSICIAN TELEPHONE _____

(Signature of Parent/Guardian) DATE: _____

STATE OF _____

COUNTY OF _____

The foregoing was acknowledged before me this _____ day of _____, 19____.

My Commission Expires: _____

Notary Public