EMERGENCY MEDICAL FORM

Name ______________________________ **Date of Birth** ______________

Address ____

Home Phone ____________________ **Cell Phone** ____________________

In Case of Emergency Notify:

Name ______________________________ **Relationship** ______________

Address ______________________________ **Phone** ______________

Family Physician ______________________________ **Phone** ______________

Health Insurance Carrier ____________________ **Policy/Group #** ______________

Prescribed or over-the-counter medications? _______ **Explain** ____________________

Are Immunizations Current? ____________ **Date of Last Tetanus Booster** ______________

Allergies / Reaction ____

Health Conditions, Chronic or Recurring Illnesses (check all that apply):

_____ **Asthma** _____ **Diabetes** _____ **Hypertension** _____ **Seizures** _____ **Heart Defect/Disease**

_____ **Hearing Impairment** _____ **Motion Sickness** _____ **Wear Glasses or Contacts**

_____ **Sleep Disturbances** _____ **Special Dietary Regimen** _____ **Other** ______________

Please explain any information useful in relation to any of these health conditions:

____

____

This health history is correct and the participant is able to engage in all activities (except as noted).

Signature ______________________________ **Date** ______________

(Parent/Guardian must sign for minors)

EMERGENCY MEDICAL AUTHORIZATION:

PURPOSE: To authorize the provision of emergency treatment for an illness or injury (every attempt will be made to reach parent/guardian of minors).

I give my consent for emergency treatment in the emergency room of the nearest hospital/med. center.

Does a certified person have permission to administer first aid treatment in case of illness or accident?

_____ **Yes** _____ **No**

Signature ______________________________ **Date** ______________

(Parent/Guardian must sign for minors)