

Must be Notarized

FORM D

MEDICAL EMERGENCY FORM

Name (of Child) _____ Date of Birth _____
Address _____

IN CASE OF AN EMERGENCY, NOTIFY:

Name _____ Relationship; _____ Parent _____ Other _____
Address _____ City _____
State _____ Zip Code _____ Telephone Numbers: Home: (____) _____
Work: (____) _____ Cell: (____) _____

ALLERGIES (Please write YES if applicable)

Hay fever _____ Asthma _____ Sulfa _____ Poison Ivy _____
Penicillin _____ Bee Sting _____ Other _____

PLEASE CHECK IF INDIVIDUAL/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 items are YES, please submit statement of how the individual/child has been treated and with what medications.

PLEASE CHECK APPROPRIATE RESPONSE:

YES _____ NO _____ I/My child can be given aspirin or Tylenol if needed for minor pain.
YES _____ NO _____ I/MY child have/has a medical condition. If yes, please describe;
YES _____ NO _____ I/My child am/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 _____
DATE: _____

(Signature of Parent/Guardian)

STATE OF _____ COUNTY OF _____

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

My Commission Expires: _____ Notary Public _____