

EMERGENCY MEDICAL TREATMENT

CONTESTANT NAME _____ DATE OF BIRTH _____

ADDRESS _____
Street City State Zip

MOTHER'S NAME _____ Phone (Home) _____

ADDRESS _____ (Work) _____

(Cell) _____

FATHER'S NAME _____ Phone (Home) _____

ADDRESS _____ (Work) _____

(Cell) _____

LEGAL GUARDIAN'S NAME _____ Phone (Home) _____

GUARDIAN'S ADDRESS _____ (Work) _____

(Cell) _____

Please indicated first person to call incase of emergency: _____

Do you faint easily? Yes__ No__ Do you get car sick? Yes__ No__

Are you currently under a physician's care? Yes __ No __ If yes, list reason _____

Name of physician: _____ Phone _____

Address: _____

Name of dentist: _____ Phone Address: _____

Are you allergic to any food, medication, insect bites, or etc: ? Yes __ No __ If so, please list: _____

Past history of any major illness or surgery: _____

Name of Health Insurance _____ Group # _____

Consent for Medical/Dental/Surgical Treatment

Name of patient _____, minor.

Permission is hereby given to hospital, physicians, nursing staff to administer any treatment, diagnostic, therapeutic, or to administer such anesthetic or perform such surgical procedure as may be deemed necessary or advisable in the diagnosis and treatment as condition warrants, and to release information as may be necessary for claims.

Signature of Parent/Legal Guardian

Signature _____

Relationship to patient _____

Witness Signature _____ Date _____