

**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 \_\_\_\_\_