Must be Notarized **FORM D**

MEDICAL EMERGENCY FORM

Name (of Child) _____Date of Birth_____
SS#_____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 _____