EMERGENCY MEDICAL TREATMENT

CONTESTANT NAME_____ DATE OF BIRTH_____
ADDRESS_____
Street City State Zip

MOTHER'S NAME _____ Phone (Home)_____

ADDRESS_____ (Work) _____
(Cell) _____

FATHER'SNAME _____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 _____