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: (_____) _____

ALLERGIES (Please write YES if applicable)

Hay fever_____Asthma_____Sulfa_____Poison Ivy_____

Penicillin_____Bee Sting_____ Other_____

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

_____

PLEASE CHECK APPROPRIATE RESPONSE:

YES _____ NO_____ My child can be given aspirin or Tylenol if needed for minor pain.

YES _____ NO_____ My child has a medical condition. If Yes, please describe;

_____

YES _____ NO_____ My child 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