MEDICAL FORM

Please print clearly; return with event application

Name of Participant _____

Address _____

City _____ State _____ Zip Code _____

Phone ( ) _____

E-Mail _____

Parish _____

School _____

Date of Birth ____/____/____ Male ☐ Female ☐ Grade _____

Name of Adult Leader _____

EMERGENCY CONTACT INFORMATION

Parent or Guardian _____

Address _____

Phone(s) _____

Chronic Conditions (e.g. Allergies, Epilepsy; Diabetes) _____

_____

Medications _____

Medical Insurance _____ Policy Number _____

Address _____ Phone ( ) _____

Member's Name _____ Phone ( ) _____

Family Doctor _____ Phone ( ) _____

EMERGENCY MEDICAL TREATMENT

In the event of an emergency, I hereby give _____ permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers please contact:

Name & relationship: _____

Phone: _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____

Policy #: _____

Signature: _____ Date: _____

Participant's Signature _____ Date _____

Parent/Legal Guardian Signature _____ Date _____