Emergency/Medical
Information Form

GENERAL INFORMATION

Last Name:_____ First:_____ MI:_____
Address:_____
City/State/ZIP:_____
Home Phone :(___) _____ Email (optional):_____
County of Residence:_____ Sex:___ Birthdate:__/__/__ Age:_____

EMERGENCY CONTACT

Full Name:_____
Address:_____
City/State/ZIP:_____
Home Phone :(___) _____ Work Phone :(___) _____

INSURANCE INFORMATION

Primary insurance is under whose name? (E.g. name of spouse, parent, guardian, or other)

_____

Birthdate of the person:_____

Name of Insurance Company:

_____

Ins. Co. Group #:_____
Policy/Contract #:_____

Employer:_____
Address:_____
City/ST/ZIP:_____
Phone:_____
If self-employed, give occupation:_____

_____

Are there any health details or information that the attending doctor should know in case of emergency (Allergies, conditions, significant medical history, etc.)?

_____

_____

_____

CURRENT OVER-THE-COUNTER OR PRESCRIBED MEDICATIONS:

Name of Medication	Reason for Medication	Prescribing Physician

AUTHORIZATION FOR MEDICAL CARE

For those Under 18 years of age:

We, the undersigned parent(s) and/or natural guardians of _____, **a minor**, do hereby authorize Health Service Providers (and/or any other qualified adult appointed or designated by them) **(1)** consent to medical, surgical, and dental care for such minor child; **(2)** to consent to any diagnostic tests, medical, surgical, or dental procedure or treatment as may be considered therapeutically necessary by the physician, surgeon, dentist, or other health care personnel providing care for such minor child **(3)** to employ physicians, surgeons, dentists, nurses, and other health care personnel as may be deemed necessary for such minor child, **(4)** to admit such minor child to any hospital, clinic, emergency room, laboratory, or other health care or diagnostic facility for examination, treatment, surgery, or care, and **(5)** to sign all necessary consents and authorizations.

It is understood that this authorization is given in advance of the occurrence of any condition or situation which would necessitate any such medical, surgical, or dental care being required; but is given to provide authority to obtain such care if it should be required. I fully understand the consequences of the foregoing statements and sign this AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE knowingly, freely and willingly.

Signature:_____ Date:_____

PLEASE ATTACH A PHOTOCOPY OF YOUR MEDICAL INSURANCE CARD HERE