MEDICAL EMERGENCY FORM

Child's Name:_____ Birthdate:_____
Address:_____

Father's Name: _____ Phone #: _____
Mother's Name: _____ Phone #: _____

Please list emergency contacts below other than yourself:
1. Name:_____ Phone #:_____
Relationship:_____
2. Name:_____ Phone #:_____
Relationship:_____

Please complete hospital/medical information:
Insurance Co:_____Group/Policy#: _____
Phone #_____
Insured's Name:_____ Insured Soc. Sec
#:_____
Doctor's Name:_____ Doctor's Phone
#:_____

1. List allergies to drugs, medication or foods_____
2. Please list any drug(s) or medications to be taken regularly_____
3. Date of last tetanus shot: _____
4. Has there been recent illness, or exposure to contagious disease(s)?_____
If so, what?_____
5. Is this person subject to fainting?_____ Convulsive Seizures_____Diabetic_____Nose bleeds_____
Cramps_____Asthma_____ What medication is prescribed for the preceding condition?_____
6. Limitations of activity?_____
7. Is there a history of chronic infection of nose, throat, ears, sinus or lungs? _____
If so, what?_____
8. Is there a history of heart pathology requiring restricted activity? _____
9. Is this person subject to any skin disease? _____

In case of medical emergency, I understand every effort will be made to contact a parent or guardian. The information provided regarding my child's medical history and condition is complete and correct to the best of my knowledge. In the event I cannot be reached, I hereby give permission to the physician selected by Marci and Ryan Rickard to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

_____
(Name of Parent or Guardian)

_____
(Signature of Parent or Guardian)

_____
(Signature of Notary)

_____
(Date)