HEALTH AND EMERGENCY INFORMATION PARISH______________________

Activity / Event______________________________ Date of Event ___________ Location ______________________________

Participant's Name ____Sex _______Age _________Grade __________

Street Address .____Home Telephone _________________________

____
Apt # City State Zip

Father's Name ____________________________________ Place of Employment______________________________________

Work Phone______________________________________ Mobile Telephone____

Mother's Name ___________________________________ Place of Employment_______________________________________

Work Phone______________________________________ Mobile Telephone____

Persons who will care for child if parents cannot be reached:

Name ____Telephone ______________________________

Name ____Telephone ______________________________

Family Doctor's Name ____ Telephone_______________________________

Family Dentist's Name ____ Telephone_______________________________

Hospital Preference ____

Health Insurance Plan ____ Policy No. ______________________________

Medical Information____

____

____

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Allergies:____

AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parent/ parents or legal guardian of ____a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general supervision of any licensed member of the medical staff and emergency room staff, or a dentist licensed and on the staff of any acute general hospital holding a current license to operate a hospital from the State Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment of hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List restrictions: ____

____

____
Date Signature of Father, Mother, or Legal Guardian

____
Address City State Zip

(Form Print Date 5/9/06)