

A.3. EMERGENCY INFORMATION and MEDICAL AUTHORIZATION (P1 of 2)

Member Name: _____ Date of Birth: _____

EVENT INFORMATION

Event: _____

Event Dates and Location: _____

Event Description: _____

CONTACTS

Primary Contact : _____ Relationship : _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Alternate Contact: _____ Relationship : _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Alternate Emergency Contact: _____

Primary Phone: _____ Secondary Phone: _____

Regular Doctor Name and Contact Information: _____

INSURANCE INFORMATION

Carrier: _____

Policy Number: _____ Phone Number: _____

Address: _____

Name and SSN of Policy Holder: _____

EMERGENCY AUTHORIZATION

I hereby give my permission to authorize emergency medical treatment for my daughter in the event of injury or illness during the above-referenced event. The health care provider is authorized to perform necessary emergency medical services upon consent of the adult in charge from the _____ Assembly, IORG.

Signature of Parent/Legal Guardian

Date

Please complete both pages

A.3. EMERGENCY INFORMATION and MEDICAL AUTHORIZATION (P2 of 2)

MEDICAL INFORMATION

Note all conditions which apply to your daughter. Give specific cause of allergies and applicable special medical information.

<u>Allergies</u>	<u>Chronic/Recurring Illnesses</u>
Drugs/medications: _____	Diabetes: _____
Food: _____	Heart: _____
Insect Stings: _____	Epilepsy: _____
Hay Fever: _____	Asthma: _____
Poison Ivy: _____	Ear Infections: _____
Other: _____	Other: _____

Physical Limitations: _____

Date of Last:
Health Examination: _____ Tetanus Shot: _____

MEDICATION AUTHORIZATION

No Rainbow Girl shall keep medication in her possession. All medications must be turned in to the adults in charge.

- The adults in charge have my permission to dispense the following medications to my daughter:

<u>Medication Name</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Aspirin-free NSAIDS (Non-steroidal anti-inflammatory drugs such as Tylenol) may be administered to my daughter:
YES NO
If yes, amount and frequency: _____

I certify that all of the above information is correct.

Signature of Parent/Guardian Date

Please complete both pages