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EMERGENCY CONTACT FORM (PINK)

Name:_____ Birthdate:_____ Age: _____

Date Entered Into Program:_____ SSN:_____ Sex: M / F

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:(H)_____ (O)_____

INCASE OF AN EMERGENCY CONTACT:

Name**:**_____ Relationship:_____

Address (If different than above):_____

City:_____ State:_____ Zip Code:_____

Phone:(H)_____ (O)_____

INSURANCE/MEDICAL:
Are you covered by any medical coverage/insurance? Yes ❑ No ❑

Insurance Policy Holder's Name: _____

Insurance Company:_____ Policy #:_____

Group#:_____Date of Policy:_____

Employee#:_____

Physician:_____ Phone:_____

Dentist:_____ Phone:_____

Other:_____ Phone:_____

Allergies/Medical Alert:

I,_____, give consent for my child,_____ to receive immediate emergency medical care in my absence should such an event be necessary that he/she should require any emergency medical attention, treatment, medication, and/or surgery in efforts to save losses to hearing, sight, limb, and/or life.

Parent/Guardian Signature:_____ Date:_____

Witness/ED Anywhere Authorization:_____ Date:_____