Medical Form

Permission for Emergency Medical Treatment

NAME:	DATE OF BIRTH:		
ADDRESS:	City:	State:	Zip:
SOCIAL SECURITY #:			
INSURANCE COMPANY AND POLICY	Y #:		
MEDICATIONS TAKEN REGULARLY:			
ALLERGIES:			
HEALTH PROBLEMS:			
DATE OF LAST TETANUS:			
PERSON TO BE CONTACTED IN EM	ERGENCY: NAME:		
ADDRESS:			
RELATION:	PHONE: (W)	(H)
ALTERNATE PERSON TO BE CONTA	ACTED: NAME:		
ADDRESS:			
RELATION:	PHONE: (W)	(H)
I, being a person authorized by law to give such perm who is the above names subject of this from. I under condition necessitating treatment arises, and that faili reasonable precautions will be taken for safety at all t with these organizations from any liability associated	stand that all reasonable attempts will be ng to reach me, attempts to contact the a imes. I further release Vision Production	made to contact me as salternate listed above will as, Inc., Camp, Youth Lea	soon as possible after the be made. I understand that all aders, and all persons associate
SIGNATURE of subject 18 or over/otherwise Pa	(Must be signe arent or Guardian	d in front of notary)	
To Be Completed by Notary:			
STATE OF			
COUNTY OF			
I, a qualified Notary Public, in and for the county date, appear before me, and after being duly swhereto in my presence.			
DATE DOCUMENT EVECUTED:	NOTARY F		
DATE DOCUMENT EXECUTED: _			SE INCLUDE SEAL!
MY COMMISSION EXPIRES:		_	