MEDICAL EMERGENCY FORM

Date _____

Name _____ Birth date _____ Age _____
Parent/Guardian Name(s) _____
Address _____
Phone Numbers (H) _____ (W) _____ (C) _____
Emergency Contact Person Name _____**Phone** _____

Allergies (Food/Drug) _____
Current Medications _____
Any medical problem we need to be aware of in case of emergency:

_____
Other pertinent medical information _____

Over-Counter Medication

If an injury occurs to my son/daughter and emergency care is not indicated, I give permission to the leaders of REACH to authorize over the counter medication to my son (such as ibuprofen, Advil, Tylenol, etc.) to help alleviate the discomfort associated with injury until I can be reached and conferred with on the appropriate follow up care with the family physician.

_____ _____
Parent/guardian signature Date

Insurance Information

This information will only be used in the case that urgent medical care is required.

Insurance Company Name _____
Insurance Company Address _____
Phone_____
Policy Holder Name _____
SSN of Holder_____
Policy Number _____ Group/Member # _____

Authorization to release benefits to medical center/physician:

_____ _____
Parent/guardian signature Date

Authorization of Emergency Medical Treatment

This information will be kept in the possession of REACH leadership. Should the need arise this information will be given to the proper medical authorities.

I, _____ [parent/guardian], understand that in the case of illness or injury to my child, _____[child's name], REACH will try to notify me or the person I have listed above as an emergency contact. In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the REACH to 1) arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and 2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

_____ _____
Parent/guardian signature Date

PLEASE NOTE: THIS FORM MUST BE FILLED OUT IN ORDER TO ATTEND REACH PlEASE TURN IN AT CHECK-IN.