Emergency Treatment Consent Form

Child/Dependent's Name_____

Address_____City_____State_____Zip_____

Home Phone (_____)_____Date of Birth_____

Parent/Guardian _____ Cell Phone (_____)_____

Work Location: _____ Work Phone: (_____)_____

Relationship to Child_____ Email of Parent/Guardian: _____

Physician's Name_____ Physician's Phone number_____

Emergency Contact (if listed parent/guardian is unavailable)

Name_____Home Phone (_____)_____ Cell Phone(_____)_____

Address_____ City_____ State_____ Zip_____

Relationship to child_____ Work Phone (_____)_____

Health History

Special Medical Problems _____

_____

Last Tetanus Shot (Td) (MM/DD/YY) _____/_____/_____

Medications to be taken with directions: _____

_____

Medication Allergies: _____

Allergies: (hay, bees, etc):_____

History of Asthma? Y N History of seizures or other loss of consciousness? Y N

History of heart problems? Y N If yes, nature of problem:_____

May be given as necessary: Ibuprofen? Y N Tylenol? Y N

Any specific activities: Encouraged: _____

Discouraged: _____

Health Insurance Company: _____

Group Number: _____ ID Number _____

"I hereby give my consent in advance to the designated leaders _____ (name of leaders) of the Marquette County Junior Fairest of the Fair and to the physicians or hospital selected by them to render emergency treatment as in their judgment is reasonably necessary, including, but not limited to, hospitalization, diagnosis including taking specimens and x-rays, giving blood transfusions and medications, anesthesia and surgery for my dependent listed above. I understand that the leaders of this program will attempt to contact me before securing medical treatment, but that this consent is given in case I am not available in an emergency.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Non-Related Adult Witness Date