EMERGENCY MEDICAL TREATMENT

Contestant Name: _____ Date of Birth_____

Address_____
Street City State Zip

Contestant Email: _____ Cell #_____

Mother's/Guardian's Name: _____

Email: _____

Address_____
Street City State Zip

Cell #_____ Work #_____ Home #_____

Father's/Guardian's Name: _____

Email: _____

Address_____
Street City State Zip

Cell #_____ Work #_____ Home #_____

TO BE COMPLETED BY THE CONTESTANT:

Do You Faint Easily? Yes_____ No_____ Do You Get Carsick? Yes_____ No_____

Are You Currently under a Physician's Care? Yes_____ No_____ If Yes, List Reason_____

_____

Do You Take Medication Daily? Yes_____ No_____ If Yes, List Medication(s) _____

Are You Allergic To Any Food Or Have Any Special Dietary Needs (Vegan, Etc.)? Yes_____ No_____
Are You Allergic To Any Medications? Yes_____ No_____

If Yes Please List Them_____

Past History of Any Major Illness or Surgery_____

Name of Health Insurance_____ Group #_____

Name of Physician_____ Phone_____

Address_____
Street City State Zip

Name of Dentist_____ Phone_____

Address_____
Street City State Zip

CONSENT FOR MEDICAL/DENTAL/SURGICAL TREATMENT

Name of Patient _____, minor. Permission is hereby given to this hospital, its physicians and its nursing staff to administer any treatment, diagnostic, therapeutic, or to administer such surgical procedures as may be deemed necessary or advisable in the diagnosis and treatment as condition warrants, and to release information as may be necessary for hospital claims.

_____ _____
Signature of Parent/Legal Guardian Signature of Witness

_____
Relationship to Patient Date

FORM MUST BE TURNED IN WITH YOUR ENTRY FORM