EMERGENCY MEDICAL TREATMENT FORM

Update of information will be the responsibility of the participant, parent or guardian. NOTE: This form will be used only when an emergency contact cannot be notified and emergency medical attention is needed. Form must be notarized and a copy of participant's medical insurance card attached.

Participant Full Name:_____ DOB: _____

Participant Address: _____ Phone _____ Age ____
City, State, Zip

Participant's emergency contact Name: _____ Phone _____

Alternate emergency contact Name: _____ Phone _____

Medical Insurance Company:_____ Policy # _____

Insurance Company Phone:_____ Group #_____

Primary Insured:_____ Relationship to Participant: _____

Is participant presently under medical treatment/taking medication? Yes_____ No_____

If yes, describe:_____

Frequency of medication:_____

PAST MEDICAL HISTORY:

Are any of the following applicable to participant?

Asthma____ Sinusitis____ Bronchitis____ Kidney Trouble____ Heart Trouble____ Diabetes ____

Dizziness____ Hay Fever____ Other _____

Any previous operations or serious illnesses:_____

List allergies, if any, including allergies to medicines:_____

List any other physical condition(s) of which St. Andrew Baptist Church should be aware:_____

The undersigned participant _____
or parent/guardian of (enter participant name if under age 18) _____
hereby consent to any and all emergency medical and surgical treatments, including anesthesia and surgical procedures, which may be deemed advisable by qualified physicians selected by agents or officials of St. Andrew Baptist Church. The intention thereof is to grant authority to administer and to perform examinations, treatments, anesthesia, surgical procedures, and diagnostic procedures which may now, or during the course of the patient's care, be deemed advisable or necessary by qualified physicians.

IN WITNESS of our consent and agreement to the matters stated above, we have subscribed our signatures below: (Sign in presence of Notary)

Date_____ Participant/Parent/Guardian Signature _____

Date_____ Participant/Parent/Guardian Signature _____

State of Florida, County of Bay.
I, the undersigned authority, a Notary Public in and for said County in said State, hereby certify that the above named person who is known to me or has produced _____ as identification.

Sworn and subscribed before me this _____ day of _____, 20____

Notary Signature_____

My Commission Expires_____

Notary Seal

ATTACH COPY OF MEDICAL INSURANCE CARD (front & back)