

# Medical Form

## Permission for Emergency Medical Treatment

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

INSURANCE COMPANY AND POLICY #: \_\_\_\_\_

MEDICATIONS TAKEN REGULARLY: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

HEALTH PROBLEMS: \_\_\_\_\_

DATE OF LAST TETANUS: \_\_\_\_\_

PERSON TO BE CONTACTED IN EMERGENCY: NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

RELATION: \_\_\_\_\_ PHONE: (W) \_\_\_\_\_ (H) \_\_\_\_\_

ALTERNATE PERSON TO BE CONTACTED: NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

RELATION: \_\_\_\_\_ PHONE: (W) \_\_\_\_\_ (H) \_\_\_\_\_

I, being a person authorized by law to give such permission, do hereby give my permission for emergency medical treatment to be given to the person who is the above names subject of this form. I understand that all reasonable attempts will be made to contact me as soon as possible after the condition necessitating treatment arises, and that failing to reach me, attempts to contact the alternate listed above will be made. I understand that all reasonable precautions will be taken for safety at all times. I further release Vision Productions, Inc., Camp , Youth Leaders, and all persons associated with these organizations from any liability associated with any accident, injury, or disease to the person that is subject to this form.

\_\_\_\_\_  
**SIGNATURE** of subject 18 or over/otherwise Parent or Guardian **(Must be signed in front of notary)**

**To Be Completed by Notary:**

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

I, a qualified Notary Public, in and for the county aforesaid, hereby certify that the person whose signature appears above did, on this date, appear before me, and after being duly sworn or affirmed, and reading, this document in its entirety did affix his or her signature hereto in my presence.

\_\_\_\_\_  
**NOTARY PUBLIC**

DATE DOCUMENT EXECUTED: \_\_\_\_\_

**PLEASE INCLUDE SEAL!**

MY COMMISSION EXPIRES: \_\_\_\_\_