Pumpkinvine Baptist Church

Authorization for Medical Treatment

Date: _____

To Whom It May Concern:

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child _____, SS# _____, in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if the situation warrants.

NAME OF CHILD: _____ D.O.B _____ AGE_____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

NAME OF FAMILY PHYSICIAN: _____ PHONE: _____

ALLERGIES OF CHILD: _____

LAST MEDICAL ATTENTION: TYPE: _____ DATE: _____

PHYSICIAN: _____DATE OF LAST DPT OR TETANUS: _____

NAME OF INSURANCE COMPANY (MEDICAL): _____

POLICY # _____ EXPIRATION DATE: _____

Please provide and attach a copy (both front and back) of insurance card.

EMERGENCY PHONE NUMBERS:

FATHERS NAME: _____ MOTHERS NAME: _____

FATHER'S # AT WORK: _____ AT HOME: _____

PLACE OF EMPLOYMENT: _____ SS# _____

MOTHER'S # AT WORK: _____ AT HOME: _____

PLACE OF EMPLOYMENT: _____ SS# _____

FAMILY MEDICAL HISTORY: Has any blood relative ever had any of the medical conditions listed below? Please check the correct response. (Please check one for every condition)

Medical Condition	Yes	No	Medical Condition	Yes	No
Cancer			Stroke		
Tuberculosis			Epilepsy		
Diabetes			Heart Trouble		
High Blood Pressure			Bleeding Disease		
Kidney Disease			Other:		

SERIOUS INJURIES: (such as concussion, fracture, etc.) Please list below, if none, please write 'none' across the table below.

Type of Injury	Date	Physician	Physician Phone #

PERSONAL MEDICAL HISTORY: Have you ever had any of the medical conditions listed below? Please check the correct response.

Medical Condition	Yes	No	Medical Condition	Yes	No	Medical Condition	Yes	No
In the past ten years have you had a PPD (TB skin test)			In the past ten years have you had a Tetanus shot			Other:		
Red Measles			German Measles			Mumps		
Whooping Cough			Diphtheria			Small Pox		
Chicken Pox			Typhoid Fever			Influenza		
Pneumonia			Scarlet Fever			Tuberculosis		
Polio			Meningitis			Asthma		

ALLERGIES: If you have any of the following allergies, please check the correct response. (Please leave nothing blank)

Allergy	Yes	No	Reaction (If Yes)	Allergy	Yes	No	Reaction (If Yes)
Penicillin				Eggs			
Sulfa				Insect Bites			
Barbiturates				Other Allergy			

PREVIOUS SURGERIES: Please list below, if none, please write 'none' across the table below.

Previous Surgeries	Date	Physician	Physician Phone #

PREVIOUS HOSPITALIZATIONS: Please list below, if none, please write 'none' across the table below.

Previous Hospitalizations	Date	Physician	Physician Phone #

Signature of Parent or Guardian: _____

NOTARIZATION REQUIRED: (Notary available through Pumpkinvine Baptist Church)

Witness my hand and official seal, this _____ Day of _____, 20_____.

My Commission Expires: _____

_____

Notary Public State of Georgia at large, County of _____.