



# Confidential Medical Information and Emergency Notification Form (Chaperone)

Name: \_\_\_\_\_ Birthdate: (MM/DD/YY): \_\_\_\_\_

Sex: M F

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Physician: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

## Emergency Notification Information

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Chaperone: \_\_\_\_\_

Medical/ Hospital Insurance Carrier: \_\_\_\_\_

Policy #: \_\_\_\_\_

Insurance Carrier Phone # (1-800): \_\_\_\_\_

## **Consent to Medical Care and Treatment**

I hereby authorize and consent to the administration of all medical and/or surgical treatment(s) to my child by a licensed physician or hospital in the event I am not available to consult with the attending physician(s), attempts to contact me have been unsuccessful, and the attending physician(s) deem it advisable to proceed with such treatment(s).

Chaperone Signature: \_\_\_\_\_ Date: \_\_\_\_\_