MEDICAL INFORMATION AND EMERGENCY MEDICAL TREATMENTS AUTHORIZATION FORM

This form is required for all Key Club Members and every other person under the age of 18 attending the Holiday Social Conference. This form must be notarized. The completed and notarized original copy will be verified by the conference leaders and then given to the attending adult from your district. **Please type or print all information.**

Student's Name_____
Address_____
_____
Height_____Weight_____Sex_____
Social Security #_____
Date of Birth_____

First Person to be contacted in case of Emergency:

_____
Relationship to Student_____
Home Phone_____
Work Phone_____
Cell Phone_____

Second Person to be contacted in case of Emergency:

_____
Relationship to Student_____
Home Phone_____
Work Phone_____
Cell Phone_____

Name of Physician:_____
Address_____
_____
Phone_____
Name of Health Insurance Provider:
_____
Policy #_____
List any other pertinent information shown on insurance card:
_____
_____
_____

PLEASE ANSWER	**YES OR NO**
1. Will the student be taking drugs or medication of any type during the event?	_____
2. Has the student ever been treated for any of the following:	
Nervousness?	_____
High Blood Pressure?	_____
Any Mental Disorder?	_____
Severe/Frequent Headaches?	_____
Convulsions or Epilepsy?	_____
Asthma?	_____
Fainting Spells?	_____
Ulcers?	_____
Heart Conditions?	_____
Diabetes?	_____
Rheumatic Fever?	_____
Allergic Reaction to Medication?	_____
Cancer or Tumor?	_____
Other Allergies/illnesses?	_____
3. Does the student have any other physical limitations?	_____

(If currently being treated for any of the above or any other medical condition, please indicate below.)

Please give details of YES answers to any of the questions above.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please read carefully:
I hereby certify that the information given on this form is correct. In case of medical emergency, I understand that every effort will be made to contact the person(s) designated above. In the event those person(s) cannot be reached or time does not permit, I hereby give permission to a licensed physician to provide proper treatment for, and including, hospitalization, immunization or injection, anesthesia, or surgery for the student named above.

Signature of Parent or Guardian:

_____
Date:_____

For Notary Public: Subscribed and sworn before me

this_____day of_____, 20_____,

_____Notary Public

of the County of _____, in the State of _____.

My Commission Expires_____.

NOTARY SEAL
(Required)