HOSPITAL MEDICAL INFORMATION

Attention Parents/Legal Guardians
This form will be used in the event we need to transport your child for medical attention.

EMERGENCY DEPARTMENT
PATIENT CONSENT FORM

FULL NAME (CHILD): _____ AGE: _____

NAME (PARENT/GUARDIAN)_____

ADDRESS(HOME): _____ D.O.B.: _____

TELEPHONE # (PRIMARY # to call)_____

PHONE # (CELL): _____ PHONE# (WORK): _____

SECOND CONTACT PERSON & PHONE # _____

NAME OF PERSON CARRYING INSURANCE: _____

INSURANCE CO: _____ POLICY ID _____

PEDIATRICIAN: _____

CURENT MEDICATIONS: _____

_____

DOES YOUR CHILD NEED TO TAKE MEDICATION AT THE PROGRAM: Yes No

If yes, an additional Medical Authorization form must be completed if child is to receive any medication during program hours. This includes epi-pens, prescriptions and over-the-counter medications. Please download the forms from our website at www.thompsonrec.org or call 923-9440.

ALLERGIES TO MEDICATIONS: _____

_____

IMPORTANT MEDICAL HISTORY (EMOTIONAL & PHYSICAL)

_____

_____

LAST TETANUS IMMUNIZATION: _____

I, parent or legal guardian, give my consent for Thompson Recreation staff, to contact the above named physician if my child has a medical emergency. I understand that if my child's physician is not available, or if emergency requires immediate transportation by ambulance, my child may be transported to Day Kimball Hospital, or the nearest hospital to location of incident. I also give my consent for the emergency evaluation, treatment, and/or admission to above mentioned hospital and will be responsible for all medical charges.

DATED: _____ SIGNATURE: _____

IT IS VITAL THAT YOU COMPLETE THE ABOVE FORM IN ITS ENTIRETY. PLEASE LIST ANY AND ALL ALLERGIES, MEDICAL CONDITIONS THAT THE STAFF SHOULD BE AWARE OF.