

# THOMPSON RECREATION - HOSPITAL MEDICAL INFORMATION

Attention Parents/Legal Guardians

This form will be used in the event we need to transport your child for medical condition.

## EMERGENCY DEPARTMENT PATIENT CONSENT FORM

FULL NAME (PATIENT): \_\_\_\_\_ D.O.B.: \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_

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

TELEPHONE (PRIMARY) \_\_\_\_\_ PHONE (WORK): \_\_\_\_\_

NAME OF PERSON CARRYING INSURANCE: \_\_\_\_\_

INSURANCE CO & POLICY # \_\_\_\_\_

PEDIATRICIAN'S NAME: \_\_\_\_\_

PEDIATRICIAN'S PHONE #: \_\_\_\_\_

ALLERGIES TO MEDICATIONS & FOOD \_\_\_\_\_

IMPORTANT MEDICAL HISTORY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE OF 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, your 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.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_