Y.E.S. Emergency Medical Form

This completed form must be brought to registration by each person attending. **Please PRINT information clearly with blue or black ink**. Please also be sure to bring a copy of your medical health insurance card.

Name:_____ DOB___/___/___ Age ____
Last First M.I. M D Y

Address:_____
Number and Street City/State/Zip

Phone: (_____)_____ Cell: (_____)_____

Name two Parents/relatives/friends who may be contacted in case of an emergency:

1. Name: _____ Relationship:_____

Address: _____

Phone: (_____)_____ Cell: (_____)_____

2. Name: _____ Relationship:_____

Address: _____

Phone: (_____)_____ Cell: (_____)_____

PHYSICIAN: Doctor's name:_____

Address:_____

Phone: (_____)_____

*****ALLERGIES: Do you have any allergies to food?_____ If yes, list which food(s):

_____ _____ _____

_____ _____ _____

Do you have any known allergies to drugs/medicine?_____ If yes, list which drug(s):

_____ _____ _____

_____ _____ _____

MEDICATION: Are you bringing medication with you? _____ If yes, give name(s):

_____need refrigerated? ____ _____ ____

_____need refrigerated? ____ _____ ____

_____need refrigerated? ____ _____ ____

(Note: Directions for administering, name of medication, and patient's name **must** be on the label.)

The attendee will be responsible for administering all medication him/herself. I recognize that Y.E.S. staff will not be responsible, in any way, for supervising medication.

In the event of an emergency, I certify I am over the age of 18 and hereby give permission for the physician selected by the officials of this organization to provide whatever medical or surgical treatment is necessary.

Signed_____ Date_____

Print name_____

(If signing for a minor, please check one: Parent_____ Legal Guardian_____)

**** Please be sure to bring a copy of your medical health insurance card.**