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: (_____)______________________

Past Medical History (Please provide any information we would need to know in an emergency)

____

____

*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.**