

# SOUTHERN CALIFORNIA CONFERENCE

## Emergency Medical Treatment Authorization Form

Name \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

In case of emergency notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Other number ( ) \_\_\_\_\_

### Health History:

Have you ever had: (Answer "yes" or "no")

Hypoglycemia _____	Asthma _____	Fainting spells _____
Headaches _____	Hay fever _____	Seizures _____
Heart trouble _____	Diabetes _____	Lung problem _____
High blood pressure _____	Allergic to bee/wasp stings _____	

Allergies or reactions to medication? \_\_\_\_\_ If so, what? \_\_\_\_\_

Explain any illness or limitation of activity \_\_\_\_\_

Do you wear glasses? \_\_\_\_\_ Contact lenses? \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

### Parent's Authorization: (Required for those under 18 years of age)

This health history is correct as far as I know. I hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of any physician the adult leader may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital.

Signature of parent or guardian \_\_\_\_\_

Event \_\_\_\_\_ Date \_\_\_\_\_

Departure: Day \_\_\_\_\_ Time \_\_\_\_\_

Arrival: Day \_\_\_\_\_ Time \_\_\_\_\_