Medical Form

Permission for Emergency Medical Treatment

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____City: _____ State: _____ Zip: _____

SOCIAL SECURITY #: _____

INSURANCE COMPANY AND POLICY #: _____

MEDICATIONS TAKEN REGULARLY: _____

ALLERGIES: _____

HEALTH PROBLEMS: _____

DATE OF LAST TETANUS: _____

PERSON TO BE CONTACTED IN EMERGENCY: NAME: _____

ADDRESS: _____

RELATION: _____ PHONE: (W)_____(H)_____

ALTERNATE PERSON TO BE CONTACTED: NAME: _____

ADDRESS: _____

RELATION: _____ PHONE: (W)_____(H)_____

I, being a person authorized by law to give such permission, do herby give my permission for emergency medical treatment to be given to the person who is the above names subject of this from. I understand that all reasonable attempts will be made to contact me as soon as possible after the condition necessitating treatment arises, and that failing to reach me, attempts to contact the alternate listed above will be made. I understand that all reasonable precautions will be taken for safety at all times. I further release Vision Productions, Inc., Camp , Youth Leaders, and all persons associated with these organizations from any liability associated with any accident, injury, or disease to the person that is subject to this form.

_____ **(Must be signed in front of notary)**
SIGNATURE of subject 18 or over/otherwise Parent or Guardian

To Be Completed by Notary:

STATE OF_____

COUNTY OF_____

I, a qualified Notary Public, in and for the county aforesaid, hereby certify that the person whose signature appears above did, on this date, appear before me, and after being duly sworn or affirmed, and reading, this document in its entirety did affix his or her signature hereto in my presence.

_____
NOTARY PUBLIC

DATE DOCUMENT EXECUTED: _____ **PLEASE INCLUDE SEAL!**

MY COMMISSION EXPIRES: _____