

Health Information and Emergency Authorization

Please place this form in a sealed envelope with your name on the outside. The form will be confidentially held by the Bus Mom to be passed along to appropriate personnel in the event of an emergency.

Name_____

Address_____

City_____ State_____ Zip_____

Significant Medical History (i.e. asthma, diabetes, heart condition, recent surgeries)

Significant Allergies to medications or foods

Current Medications

Hospital/Clinic of Record_____

Physician_____ Phone_____

Insurance Company_____ Policy or Group #_____

Emergency Authorization: I give my permission to local physician to hospitalize, treat, order injections, anesthesia or surgery if the contact person cannot be reached.

Signature_____ Date_____

Medical costs incurred while on this event are the sole responsibility of the Participant. Participant assumes all risk and expense related to accidental injury.

Signature_____ Date_____