Indiana Royal Rangers

Medical Information
Emergency Treatment Authorization

Church	
Sponsor	

Office Use Only

Name		Date of Birth / /
Address		Phone
City, State, Zip		
Parent or Guardian Name		
Street Address		Check if same as above ☐
City, State, Zip		Phone
Place of Employment		Work Phone
In Case of Emergency Notify: Relationship to Student :		Phone
Covered by Medical Insurance? ☐ No ☐ Yes	Insurance Company	Policy # ☐ Group ☐ Individual
	Primary's Name	Primary's Social Security #
Physician Name and Phone #		
Past Medical History (any injuries, illnesses, current medications, etc.)		
Are you allergic to any medications? ☐ No ☐ Yes If Yes, list any:		
Do you have any general allergies? ☐ No ☐ Yes If Yes, list any and the reaction:		
Last Tetanus Vaccination / /		
Other Vaccinations with date: ☐ No ☐ Yes		

AUTHORIZATION

As the legal parent or guardian of above named minor, I give permission to the acting church sponsor to secure and administer treatment, including hospitalization, for my child. In the event that I cannot be reached in an emergency, I authorize said sponsor to sign on my behalf, permitting my child to treated and I agree to be financially responsible for treatment..

Signed	Date / /
Witness Signature	Date / /