SOAR Fox Cities
211 E. Franklin St. Suite A
Appleton, WI 54911
(920)731-9831

EMERGENCY TREATMENT

Name: _____

Address: _____City & Zip _____

Phone: _____ Date of Birth: _____

Physician: _____ Phone: _____

HEALTH INFORMATION

Medication and dosage:

_____ _____/day

_____ _____/day

_____ _____/day

_____ _____/day

☐ Additional medications see attached page

_____ I DO NOT TAKE ANY PRESCRIPTION MEDICATIONS.

Date of last tetanus shot: _____

Known Allergies: _____

Medical Conditions/Limitations: _____

INSURANCE

Is the person covered by family medical/hospital insurance? ___ YES ___ NO

Health Insurance Company: _____

Policy Number:

_____

PERMISSION TO PROVIDE EMERGENCY CARE

I hereby give permission to the personnel selected by the Camp Director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for myself/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

_____ _____

Signature of adult or parent/guardian if under 18 years of age *Date*

Emergency Contact: _____

Phone #: (daytime) _____ (evening)_____