

# Pumpkinvine Baptist Church

## Authorization for Medical Treatment

Date: \_\_\_\_\_

To Whom It May Concern:

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child \_\_\_\_\_, SS# \_\_\_\_\_, in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if the situation warrants.

NAME OF CHILD: \_\_\_\_\_ D.O.B \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

NAME OF FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

ALLERGIES OF CHILD: \_\_\_\_\_

LAST MEDICAL ATTENTION: TYPE: \_\_\_\_\_ DATE: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ DATE OF LAST DPT OR TETANUS: \_\_\_\_\_

NAME OF INSURANCE COMPANY (MEDICAL): \_\_\_\_\_

POLICY # \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

**Please provide and attach a copy (both front and back) of insurance card.**

### EMERGENCY PHONE NUMBERS:

FATHERS NAME: \_\_\_\_\_ MOTHERS NAME: \_\_\_\_\_

FATHER'S # AT WORK: \_\_\_\_\_ AT HOME: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_ SS# \_\_\_\_\_

MOTHER'S # AT WORK: \_\_\_\_\_ AT HOME: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_ SS# \_\_\_\_\_

**FAMILY MEDICAL HISTORY:** Has any blood relative ever had any of the medical conditions listed below? Please check the correct response. (Please check one for every condition)

Medical Condition	Yes	No	Medical Condition	Yes	No
Cancer			Stroke		
Tuberculosis			Epilepsy		
Diabetes			Heart Trouble		
High Blood Pressure			Bleeding Disease		
Kidney Disease			Other:		

**SERIOUS INJURIES:** (such as concussion, fracture, etc.) Please list below, if none, please write 'none' across the table below.

Type of Injury	Date	Physician	Physician Phone #

**PERSONAL MEDICAL HISTORY:** Have you ever had any of the medical conditions listed below?  
Please check the correct response.

Medical Condition	Yes	No	Medical Condition	Yes	No	Medical Condition	Yes	No
In the past ten years have you had a PPD (TB skin test)			In the past ten years have you had a Tetanus shot			Other:		
Red Measles			German Measles			Mumps		
Whooping Cough			Diphtheria			Small Pox		
Chicken Pox			Typhoid Fever			Influenza		
Pneumonia			Scarlet Fever			Tuberculosis		
Polio			Meningitis			Asthma		

**ALLERGIES:** If you have any of the following allergies, please check the correct response. (Please leave nothing blank)

Allergy	Yes	No	Reaction (If Yes)	Allergy	Yes	No	Reaction (If Yes)
Penicillin				Eggs			
Sulfa				Insect Bites			
Barbiturates				Other Allergy			

**PREVIOUS SURGERIES:** Please list below, if none, please write 'none' across the table below.

Previous Surgeries	Date	Physician	Physician Phone #

**PREVIOUS HOSPITALIZATIONS:** Please list below, if none, please write 'none' across the table below.

Previous Hospitalizations	Date	Physician	Physician Phone #

**Signature of Parent or Guardian:** \_\_\_\_\_

NOTARIZATION REQUIRED: (Notary available through Pumpkinvine Baptist Church)

Witness my hand and official seal, this \_\_\_\_\_ Day of \_\_\_\_\_, 20\_\_\_\_\_.

My Commission Expires: \_\_\_\_\_

\_\_\_\_\_  
Notary Public

State of Georgia at large, County of \_\_\_\_\_.