

Troop 681 Emergency Medical Treatment Form for Adults

Emergency Treatment Release Statement: I hereby authorize the Troop Leadership and/or any licensed physician, EMT or other qualified hospital personnel to render medical treatment, which, in their judgment is necessary in the event of incapacitating illness or injury to myself. I understand that, in all such cases, my designees will be notified as quickly as possible.

Full Name, Printed: _____

(Signature) (Date)

Date Of Birth: _____

Full Address: _____

Home Phone Number: _____

Husband's/Wife's Work Number: _____

Additional Permanent Emergency Number: _____

Name of person to contact at this latter number: _____

Relationship to Family: _____

Please list any and all allergies, special medical conditions, special medications or health problems with which Troop 681 should be aware:

Are there any medications that you know of that are contraindicated for medications you are currently taking on a regular basis? Please list any and all medications that you take on a regular basis. Please include amounts taken, number of daily doses and routine administration times:

Blood type (if known): _____

Do you wear contact lenses?: _____

Name of Family Doctor: _____

Office Phone Number: _____

Emergency Phone Number: _____

Medical Insurance Policy Name and Number: _____

Emergency (or Prior Approvals) Phone Number: _____

Name of Family Dentist: _____

Office Phone Number: _____

Emergency Phone Number: _____

Dental Insurance Policy Name and Number: _____

Emergency (or Prior Approvals) Phone Number: _____

Optional:

Are you an Organ Donor? _____

Do you have a "Living Will" arrangement? _____

Please use the free space below, as needed, to detail any necessary additional directions or clarifications. Please note that this information is held in strict confidence.