

**MEDICAL QUESTIONNAIRE  
EMERGENCY MEDICAL TREATMENT AUTHORIZATION FORM**

Key Clubber's name \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip

Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_ Birthday \_\_\_\_\_

Person to Contact in case of emergency \_\_\_\_\_

Relationship to student \_\_\_\_\_

Phone(H) Phone(W)

Alternate Contact \_\_\_\_\_

Name Relationship Phone

Doctor Information \_\_\_\_\_

Name

Street Address City State Zip Telephone

Name of Health Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Insured \_\_\_\_\_

Address of Insured \_\_\_\_\_

City State Zip Telephone

Employer of Insured \_\_\_\_\_ Employer Phone# \_\_\_\_\_

Insurance Company's phone number \_\_\_\_\_

List any other pertinent information of insurance card \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS YES OR NO:**

1. Will this student be taking medication of any type? \_\_\_\_\_ If yes please list medications.
2. Has he/she ever been treated for: (If currently being treated please indicate)
 

A. Nervousness _____	H. High Blood Pressure _____
B. Any Mental Disorder _____	I. Frequent Headaches _____
C. Convulsions/Epilepsy _____	J. Asthma _____
D. Fainting Spells _____	K. Ulcers _____
E. Heart Condition _____	L. Diabetes _____
F. Rheumatic Fever _____	. Any Allergies _____
G. Cancer or Tumor _____	N. Other Illnesses _____
3. Does he/she have any other physical limitations? \_\_\_\_\_

Give details of yes answers to any of the questions above. Give dates of treatment, and names and addresses of attending physicians, hospitals, and clinics. (Use reverse side if needed) \_\_\_\_\_

I certify that the information on this form is correct. In case of emergency, I understand that every effort will be made to contact the person listed above. In the event that person cannot be reached or time does not permit, I give permission to a licensed physician to provide proper treatment, including hospitalization, immunization or injection, anesthesia, or surgery, for my son or daughter.

Signature of Parent or Guardian \_\_\_\_\_

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

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

state of \_\_\_\_\_. My Commission Expires \_\_\_\_\_. Seal