

**Emergency Medical Form**

Milford First UMC

In the event of an emergency, I give permission for the group leader to obtain medical treatment at the nearest hospital or doctor, at my expense, and in accordance with any medical restrictions I have included with this form.

**Name of Participant:** \_\_\_\_\_

**Health Insurance Company:** \_\_\_\_\_ **Policy or ID Number:** \_\_\_\_\_

**Doctor** (*name, address, phone*) \_\_\_\_\_

**Current Medications of Participant:** \_\_\_\_\_

**Participant Allergies:** \_\_\_\_\_

**Emergency Contact #1: Name:** \_\_\_\_\_

*Best Contact Phone:* \_\_\_\_\_ *Relationship to Participant:* \_\_\_\_\_

**Emergency Contact #2: Name:** \_\_\_\_\_

*Best Contact Phone:* \_\_\_\_\_ *Relationship to Participant:* \_\_\_\_\_

**Emergency Contact #3: Name:** \_\_\_\_\_

*Best Contact Phone:* \_\_\_\_\_ *Relationship to Participant:* \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*Please include anything else noteworthy for the group leader(s) concerning the participant on the back of this page.**