



EMERGENCY MEDICAL/DENTAL CARE AUTHORIZATION

In cases of illness or injury requiring emergency medical attention, the Armed Services YMCA Facilitators will seek out such services as are deemed necessary for the health and safety of your child. This may include: basic first aid provided by a facilitator; seeking care from a preferred medical or dental provider; or contacting emergency services to transport your child to the nearest medical treatment facility. In all cases, every effort will be made to reach a parent or guardian at the earliest opportunity.


By completing and signing this form, the parent(s) or guardian(s) identified on this form authorize the ASYMCA Facilitator to exercise their best judgment in what constitutes an emergency requiring medical intervention for the child identified herein. Additionally, the parent(s) or guardian(s) consent to accept financial responsibility for any costs incurred for such medical intervention.


CHILD'S INFORMATION

Child's Full Name: _____ Child's Date of Birth: _____
Child's Address: _____
City: _____ State: _____ Zip: _____

Medical Information

This information may be provided to a medical or dental provider during an emergency. Providing a brief medical history may be critical to a medical or dental provider's ability to offer safe and appropriate treatment options.

 Known Medical Conditions or Allergies: _____

 Current Medications or Supplements: _____

PARENT/GUARDIAN #1

Name: _____ Relationship to Child _____
Mobile Phone: _____ Alternate Phone _____ ☐ Work ☐ Home ☐ Other

PARENT/GUARDIAN #2

Name: _____ Relationship to Child _____
Mobile Phone: _____ Alternate Phone _____ ☐ Work ☐ Home ☐ Other

EMERGENCY CONTACT

Name: _____ Relationship to Child _____
Mobile Phone: _____ Alternate Phone _____ ☐ Work ☐ Home ☐ Other

MEDICAL PROVIDER

Preferred Primary Care Provider

Name: _____

Address: _____

Preferred Hospital or Clinic

Name: _____

Address: _____

Medical Insurance

Company: _____

Phone: _____

Policy Number: _____

Member's Name: _____

Group Number: _____

DENTAL PROVIDER

Preferred Dental Provider

Name: _____

Address: _____

Preferred Dental Clinic

Name: _____

Address: _____

Dental Insurance

Company: _____

Phone: _____

Policy Number: _____

Member's Name: _____

Group Number: _____

AUTHORIZED SIGNATURE

In the event of a medical or dental emergency, I authorize the Armed Services YMCA's (ASYMCA) Facilitator to obtain emergency services for my child, up to and including emergency transport to the nearest hospital. I understand that that every effort will be made to notify the parent(s) or guardian(s) immediately, and that ASYMCA Facilitators will use their best judgment in determining what constitutes a medical or dental emergency. Furthermore, I understand that I am responsible for the costs of any emergency transportation and/or medical or dental care provided.

Signature of Parent or Guardian #1

Date

Signature of Parent or Guardian #2

Date