



Golden Heart Ranch Social Living Club Medical Emergency Information

Please Print Clearly

Participant's Name _____ Last _____ First _____ M.I. _____ DOB: __/__/__

Doctor Name _____ Doctor Phone _____

Insurance Company Name _____ Insurance Company Phone _____

Subscriber / Member ID# _____ Group # _____

Name of Policy Holder _____

Does Insurance Company require pre-authorization? Yes/No. If yes, pre-authorization phone _____

Allergies (foods, meds, bites, stings etc.)

Current Medications (including dosage and frequency):

In Case of Emergency Contacts **(we recommend at least 3 emergency contacts)**

Contact Person	Phone Number (indicate cell or home)	Relationship to Participant

I (we) the undersigned parents(s) or legal guardian of _____, a minor, do hereby authorize and consent to any medical/dental, x-ray examination, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and it to be rendered under general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act and or the staff of any acute general hospital/dentist holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorizes and empowers the aforementioned physician in the exercise of his best judgment to render care which he may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions

Parent/Guardian Signature

Date