MEDICAL FORM AND AUTHORIZATION

NAME: _____

ADDRESS: _____

PHONE #: _____ DATE OF BIRTH _____

Name of relative to be contacted in case of emergency, Phone _____

Physician _____Phone # _____

Allergies (including medication) _____

_____

Under any medical problems and/or medications being taken _____

_____

_____

Please check if you have had any of the following in the past **FOUR YEARS**:

_____ Asthma
_____ Epilepsy
_____ Stroke
_____ Angina-chest pain
_____ Fractures or broken bones
_____ Diabetes
_____ Other: (please explain on reverse)

_____ Hepatitis
_____ Bronchitis
_____ Heart Attack
_____ Ulcers- stomach/ intestinal
_____ Fainting/ dizzy spells
_____ Shortness of breath

Insurance Company/ID Number _____

I hereby give my consent for a qualified physician or surgeon to examine, diagnose, prescribe and perform treatment, including surgery, that he deems advisable for the welfare of the above listed patient.

I hereby give consent for the transfer of the member to any hospital reasonably accessible.

I understand that no one connected with Pride of Cincinnati or the Pride Youth Development Foundation assumes liability for any injury incurred by the participant. I agree to pay all medical costs incurred by the participant including hospital bills, physician fees, and ambulance fees.

I understand that someone in authority will contact the relative listed above at the time they are admitted to the hospital and /or treated by a physician.

Signed: _____

Date: _____
(If under 18 must be signed by parent and notarized)