THE Miss St. George

SCHOLARSHIP PAGEANT

Medical Emergency Form

Participants Name: ____________________ DOB: __________ SSN: __________

Address: ____

City, State, Zip: ____

Parent's Names: ____

Cell Number: ____________________ Work Number: ____________________

Email Address: ____

Name of Insurance Company: ____________________ Policy No.: ____________________

Name of Family Physician: ____________________ Phone No.: ____________________

Address: ____

In the event of a serious medical emergency, I do authorize the Miss St. George Program Director and/or staff to make the necessary arrangments for treatment.

____ ____________________

Signature of Parent/Guardian Date

Do you have any known allergies? Yes No

If so, please list them: ____

List any medications you are currently taking: ____

____

Please name two people we may contact in the event parents cannot be reached:

Name: ____________________ Name: ____________________

Relationship: ____________________ Relationship: ____________________

Address: ____________________ Address: ____________________

Phone Number: ____________________ Phone Number: ____________________