



# Castle Wall Productions

## Medical Emergency Consent / Contact Form

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ 2<sup>nd</sup> Phone : \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relation to patient: \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact Number (if different from above): \_\_\_\_\_

List ANY allergies (medications, food, insects etc.): \_\_\_\_\_

\_\_\_\_\_

List ALL medications: \_\_\_\_\_

\_\_\_\_\_

List ALL medical conditions (diabetes, asthma, hypoglycemia etc.): \_\_\_\_\_

\_\_\_\_\_

List ALL injuries and surgeries: \_\_\_\_\_

\_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Physicians Address \_\_\_\_\_

Primary Insurance \_\_\_\_\_ ID # \_\_\_\_\_

Members Name \_\_\_\_\_ Group # \_\_\_\_\_

Dental \_\_\_\_\_ ID # \_\_\_\_\_

Members Name \_\_\_\_\_ Group # \_\_\_\_\_

I/we hereby grant consent to any and all health care providers designated by Castle Wall Productions to myself / my child \_\_\_\_\_ any necessary medical care as a result of any injury illness. This consent includes First Aid and transport to / from health care providers.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or legal guardian if applicable)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

All Information remains confidential and is used only in case of emergency.