Castle Wall Productions

Medical / Emergency Consent Form

Name:____ Nick Name _________________________

Address:____

Phone:__________________ 2nd Phone :________________ DOB _____________

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.