

## Medical Emergency Form and Contact List

### CONSENT FOR MEDICAL TREATMENT

As the parent, agency representative or legal guardian, I hereby give consent to the Southern California Vipassana Center to provide all emergency, medical or dental care prescribed by a duly licensed physician (MD) osteopath (DO) or dentist (DDS) for

\_\_\_\_\_  
Child's name

This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Work \_\_\_\_\_ Work Phone \_\_\_\_\_  
(employer's name)

Father's Work \_\_\_\_\_ Work Phone \_\_\_\_\_  
(employer's name)

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**ALLERGIES AND SENSITIVITIES:** Does the child have a history of skin or other untoward reactions or sicknesses following injection or oral administration of:

	Circle One	If yes, describe
a) Penicillin or other antibiotics	Yes No	_____
b) Morphine, Codeine, Demerol or other narcotics	Yes No	_____
c) Novacaine or other anesthetics	Yes No	_____
d) Aspirin, Empiricin or other pain remedies	Yes No	_____
e) Sulfa drugs	Yes No	_____
f) Tetanus antitoxin or other serums	Yes No	_____
g) Adhesive tape	Yes No	_____
h) Latex	Yes No	_____
i) Iodine or merthiolate	Yes No	_____
j) Any other drug or medication	Yes No	_____
k) Any foods, such as egg, milk or chocolate	Yes No	_____

**DRUGS TAKEN RECENTLY:** With the past six (6) months the child has taken:

**CENTER STAFF: PLEASE KEEP THIS FORM WITH YOU WHEN YOU GO TO THE DOCTOR OR HOSPITAL AND NOTIFY THE PARENTS OR GUARDIANS IMMEDIATELY.**

**IDENTIFICATION AND EMERGENCY INFORMATION**  
**To Be Completed by Parent or Guardian**

CHILD'S FIRST NAME	LAST	MIDDLE	SEX	TELEPHONE		
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	BIRTHDATE
FATHER'S FIRST NAME	LAST	MIDDLE	WORK TELEPHONE			
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE
MOTHER'S FIRST NAME	LAST	MIDDLE	WORK TELEPHONE			
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE
<i>ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY</i>						
<b>NAME</b>	<b>ADDRESS</b>			<b>TELEPHONE</b>	<b>RELATION</b>	
<i>PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY</i>						
<b>PHYSICIAN</b>	<b>ADDRESS</b>		<b>MEDICAL PLAN &amp; NUMBER</b>		<b>TELEPHONE</b>	
<b>DENTIST</b>	<b>ADDRESS</b>		<b>MEDICAL PLAN &amp; NUMBER</b>		<b>TELEPHONE</b>	
<b>IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?</b>						
----- CALL EMERGENCY HOSPITAL -----OTHER, EXPLAIN:-----						
<i>NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY</i> (CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR GUARDIAN)						
<b>NAME</b>				<b>RELATIONSHIP</b>		
<b>SIGNATURE OF PARENT OR GUARDIAN</b>					<b>DATE</b>	