St. Louis Alumnae Chapter Delta Sigma Theta Sorority, Incorporated Delta G.E.M.S. Health Information Form

		Youth's Date of Birth: / / First Middle						
Last, outh's Address:		First	Mid City:		e:	Zip:		
ame of Mother or Legal Guardian	<u>:</u>		Phone:		W	ork or Cell:		
ame of Father or Legal Guardian:	me of Father or Legal Guardian:		Phone: -	e:		Work or Cell:		
mergency Contact:								
Condition	Yes	Comments	Condition		Yes	Comments		
Allergies (food, insects, drugs, latex)			Diabetes					
Allergies (seasonal)			Head injury, cond	cussions				
Asthma or breathing problems			Hearing problems	s or deafness				
Attention-Deficit/Hyperactivity Disord	ler		Heart problems					
Behavioral problems			Lead poisoning					
Developmental problems			Muscle problems					
Bladder problem			Seizures					
Bleeding problem			Sickle Cell Disea	se (not trait				
Bowel problem			Speech problems					
Cerebral Palsy			Spinal injury					
Cystic fibrosis			Surgery					
3								
Dental problems Does your child have any signi				ay require ε	emergei	ncy medical c	are during	
Dental problems Does your child have any signifactivities with the Delta G.E.M Describe any other important h	I.S. Progra	m? □Yes □No (If s	ental allergies that m o, please list below)	llnesses, res				
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St. Louis Alumnae Chapter Delta Sigma Theta Sorority, Incorporated Delta G.E.M.S. Emergency Medical Treatment Authorization Form



Last, First Middle Youth's Address: City: State: Zip:	Youth's Name:		Youth	's Date of Birth:	/			
Name of Mother or Legal Guardian:	Last,	First	Middle					
Phone: Work or Cell: Mother/Legal Guardian's Address: City: State: Zip: Email Address: Name of Father or Legal Guardian: Relationship to Youth: Phone: Work or Cell: Father/Legal Guardian's Address: City: State: Zip: Email Address:	Youth's Address:		City:	State:	Zip:			
Mother/Legal Guardian's Address: City:State:Zip:Email Address:	Name of Mother or Legal Guardian:		Relationship to Youth:					
Mother/Legal Guardian's Address: City:State:Zip:Email Address:	Phone:	k or Cell:						
Name of Father or Legal Guardian:	Mother/Legal Guardian's Address:							
Phone: Work or Cell: Father/Legal Guardian's Address:	City: State:	Zip:	Email Address:					
Father/Legal Guardian's Address:	Name of Father or Legal Guardian:		Relat	tionship to Youth:				
City: State: Zip: Email Address:	Phone:	k or Cell:	-					
If for any reason I/we cannot be reached, please contact eh following person(s) whom I/we hereby authorize to seek emergency medical or surgical care for my/our child: Designee's Name:	Father/Legal Guardian's Address:							
or surgical care for my/our child: Designee's Name: Phone: Work or Cell: Relationship to Youth: Designee's Name: Phone: Work or Cell: Relationship to Youth: In the event that the G.E.M.S. Program is unable to reach any of the individuals named above promptly by phone, I/we authorize the G.E.M.S. Program Committee to seek and secure any emergency medical or surgical care for my/our child. I/We will be responsible for any and all expenses incurred and authorize the medical facility at which treatment is rendered to release all necessary information to my/our insurance company. Initial Here: Initial Here: Physician and Insurance Information Name of Youth's Physician: Phone: Health Insurance Company: Phone: Policy Number: Group Number: Name of Policy Holder: Name of Policy Holder: Parent/Guardian Signature: Parent/Guardian Signature: Printed Name:	City:State:	Zip:	Email Address:		_			
Designee's Name:	Designee's Name:			Work or C	Gell:			
In the event that the G.E.M.S. Program is unable to reach any of the individuals named above promptly by phone, I/we authorize the G.E.M.S. Program Committee to seek and secure any emergency medical or surgical care for my/our child. I/We will be responsible for any and all expenses incurred and authorize the medical facility at which treatment is rendered to release all necessary information to my/our insurance company. Initial Here:	Relationship to Youth:							
In the event that the G.E.M.S. Program is unable to reach any of the individuals named above promptly by phone, I/we authorize the G.E.M.S. Program Committee to seek and secure any emergency medical or surgical care for my/our child. I/We will be responsible for any and all expenses incurred and authorize the medical facility at which treatment is rendered to release all necessary information to my/our insurance company. Initial Here:	Designee's Name:		Phone:	Work or C	Sell:			
G.E.M.S. Program Committee to seek and secure any emergency medical or surgical care for my/our child. I/We will be responsible for any and all expenses incurred and authorize the medical facility at which treatment is rendered to release all necessary information to my/our insurance company. Initial Here:	Relationship to Youth:							
Health Insurance Company: Phone:	G.E.M.S. Program Committee to seek for any and all expenses incurred and	and secure any emauthorize the medic	ergency medical or surgical ca cal facility at which treatment i Initial Here:	re for my/our child. I s rendered to release	/We will be responsible			
Policy Number: Group Number: Name of Policy Holder's Employer: Parent/Guardian Signature: Parent/Guardian Signature: Printed Name:	Name of Youth's Physician:			Phone:	-			
Name of Policy Holder:Name of Policy Holder's Employer: Parent/Guardian Signature:Parent/Guardian Signature: Printed Name:Printed Name:	Health Insurance Company:			Phone:				
Parent/Guardian Signature: Printed Name: Printed Name: Printed Name:	Policy Number:		Group Number:					
Printed Name: Printed Name:	Name of Policy Holder:		Name of Policy Holder's F	Employer:				
Printed Name: Printed Name:	-							
Date:								
	Date:		Date:					