

MISS CLATSOP COUNTY PRINCESS PROGRAM

HEALTH INFORMATION FORM

Please Print

Date _____ Princess Name _____

Home Telephone Number: _____

Father's Name _____

Phone #s (Office) _____ (Cell) _____

Mother's Name _____

Phone #s (Office) _____ (Cell) _____

Please list any medical problems that we need to know about:

Family Physician: _____ Phone: _____

Allergies: Drug _____

Food _____

List any medications you are taking, do any need to be refrigerated? Yes No If yes, what are they?

Do you have any special dietary needs:

If so, what are they or how do we need to accommodate you?

EMERGENCY CONTACT other than parents: (Home and Cell preferred)

Name: _____ Home/Work: _____

Relationship: _____ Cell: _____

Medical Consent

Parental permission for treatment, in case of emergency is needed. Parents or Guardians please sign the consent below on behalf of your daughter. In case of emergency, I

_____ (name),

_____, (relationship) hereby give my permission to any medical personnel to treat my daughter,

_____ (name). I understand that every attempt will be made to contact me during this event.

Signed: _____ **Date:** _____