EMERGENCY/MEDICAL INFORMATION

Please fill this form in completely or it will be returned to	you for correc	tions.	
Name (Last, First, Middle)	Phone		
Home address			
Emergency contact	Relatio	onship	
Address of above person	Phone	e ()	
Family physician	Phone	e ()	
Are you allergic to any medication or foods? If so, please list			
List any and all medicine that you are currently taking (prescri	iption or non-pro	escription)	
3. Do you have any ongoing or chronic medical conditions? F	Please explain.		
4. Have you recently had any serious illness, injury or surge	ry? If so, pleas	e explain and give dates	
5. Do you have any medical or physical conditions that might activities?	limit your abilit	y to participate in athletic or	other physical
6. List any and all handicaps, disabilities or impairments that	apply to you		
7. Do you have any of the following conditions? Diabetes?	Asthma?	High Blood Pressure?	Epilepsy?
Name of medical insurance carrier	Phone No.		
Policy and Group Number	(Attach copy of medical insurance card)		
CONSENT FOR MEDICAL DIA We (I) hereby consent to allow The MISS DALLAS/MISS DALLAS T that shall be authorized to diagnose and treat our (my) daughter, any medical problem that may arise during her stay with the MISS D addition, we (I) hereby release The MISS DALLAS/MISS DALLAS T	EEN Pageant, In	c. to select a hospital, clinic or ALLAS TEEN Pageant. In	
Delegate's name	Signature		
Parent or Guardian	Signature		
<u>Date</u>	Phone ()	