

GOYA HEALTH PERMISSION FORM

GOYAN'S Name _____ Date of Birth _____

Address _____

Home Phone# _____

Mother/Guardian's Name _____ Cell Phone # _____

Father/Guardian's Name _____ Cell Phone# _____

Family Doctor _____ Phone# _____

Preferred Hospital _____

Dentist _____ Phone# _____

Are there any medical problems of which we should be aware? _____

Does your child:

Take prescription or over-the-counter medication on a regular basis? No__ Yes__ Name(s) _____

Have a medication allergy? No__ Yes__ Name(s) _____

Have other allergies? No__ Yes__ Types _____

Type of reaction _____

Please list the names and phone numbers of two people to contact if your child is ill or injured. In the event that you cannot be contacted, these people may need to make a medical decision.

1. Name _____ Phone # _____

2. Name _____ Phone # _____

EMERGENCY MEDICAL TREATMENT

To the Advisors and Reverend:

In the event that I am unable to be reached and my child needs EMERGENCY MEDICAL TREATMENT during any time he/she is a member of the GOYA, you have my permission, and I hereby designate you my agent to act in my child's best interest in obtaining necessary transportation and medical care until I can be contacted. I hereby release you from any claim arising out of the doctor's actions, and I assume and agree to pay for any professional medical services incurred.

Parent/Guardian signature _____ Date _____

Permission for emergency medical treatment will be effective throughout the member's enrollment. If there is any change of information, please telephone the Reverend or Advisors.

Insurance Company _____

Group ID# _____ Member # _____

Telephone # _____