

**MISS JUNIOR TEEN CONTESTANTS
BLOSSOMTIME FESTIVAL
EMERGENCY MEDICAL TREATMENT**

CONTESTANT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____
Street City State Zip

CONTESTANT'S EMAIL ADDRESS _____

MOTHER'S/GUARDIAN'S NAME _____

CELL# _____ WORK# _____ HOME# _____

ADDRESS _____

EMAIL ADDRESS _____

FATHER'S/GUARDIAN'S NAME _____

CELL# _____ WORK# _____ HOME# _____

ADDRESS _____

EMAIL ADDRESS _____

NAME OF PHYSICIAN _____ PHONE _____

ADDRESS _____
Street City State Zip

NAME OF DENTIST _____ PHONE _____

ADDRESS _____
Street City State Zip

DO YOU FAINT EASILY? Yes _____ No _____ DO YOU GET CARSICK? Yes _____ No _____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? Yes _____ No _____ IF YES, LIST REASON _____

DO YOU TAKE MEDICATION DAILY? Yes _____ No _____ IF YES, LIST MEDICATION(S) _____

ARE YOU ALLERGIC TO ANY FOOD OR HAVE ANY SPECIAL DIETARY NEEDS (VEGAN, ETC.)? ARE YOU ALLERGIC TO ANY MEDICATIONS? YES _____ NO _____

IF YES PLEASE LIST THEM _____

PAST HISTORY OF ANY MAJOR ILLNESS OR SURGERY _____

NAME OF HEALTH INSURANCE _____ **GROUP #** _____

CONSENT FOR MEDICAL/DENTAL/SURGICAL TREATMENT

Name of patient _____, **minor.**

Permission is hereby given to this hospital, its physicians and its nursing staff to administer any treatment, diagnostic, therapeutic, or to administer such surgical procedures as may be deemed necessary or advisable in the diagnosis and treatment as condition warrants, and to release information as may be necessary for hospital claims.

Signature of Parent/Legal Guardian

Signature of Witness

Relationship to Patient

Date

Form must be turned in with your Entry Form