MISS 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