

BURLESON POLICE LAW ENFORCEMENT EXPLORING PROGRAM

EMERGENCY CONSENT TO MEDICAL TREATMENT

(THIS FORM WILL BE STORED IN THE BURLESON POLICE COMMUNICATIONS CENTER IN THE EVENT OF AN EMERGENCY)

EXPLORER PERSONAL INFORMATION:

Name: _____ Date of Birth: _____
(Last, First, Middle) (MM/DD/YYYY)

Sex: _____ Race/Ethnicity: _____ Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Home Phone: _____ Cellular Phone: _____

Home Address: _____
(Street, City, State, Zip/Postal Code)

Driver License #: _____ State: _____ Class: _____ Expires: _____

Social Security Number: _____ Email Address: _____

EMERGENCY CONTACTS: *(in order of preference)* *[Parent(s)/ Guardian(s)]*

1.	_____	_____	_____
	Name	Relationship	Telephone
2.	_____	_____	_____
	Name	Relationship	Telephone
3.	_____	_____	_____
	Name	Relationship	Telephone
4.	_____	_____	_____
	Name	Relationship	Telephone

ALTERNATE CONTACTS: *(in order of preference)* *[Grandparents, Relatives, Brothers/Sisters-older than 21]*

1.	_____	_____	_____
	Name	Relationship	Telephone
2.	_____	_____	_____
	Name	Relationship	Telephone
3.	_____	_____	_____
	Name	Relationship	Telephone
4.	_____	_____	_____
	Name	Relationship	Telephone

CONSENT TO MEDICAL TREATMENT:

In the event of serious illness or injury to me or to my son/daughter while involved in any Explorer activity or Ride-Along, I/we hereby CONSENT to whatever emergency medical treatment, x-ray examination, anesthesia, medical or surgical diagnostic procedures or treatment that is considered reasonable and necessary in the best judgment of the emergency medical technician/paramedic and the attending licensed physician, and is performed under the supervision of a member of the medical staff of the hospital furnishing the medical services. It is understood that in the event of a serious illness or injury, reasonable efforts to reach me/us or an alternate member of the family will be attempted. It is also understood that in the event of a serious illness or injury, the Explorer or the parental/guardian's personal medical insurance will be utilized first to cover all costs, treatments, surgeries, medical care, and any other expenses involved in the recovery of the Explorer.

Printed Name

Signature

Date

BURLESON POLICE LAW ENFORCEMENT EXPLORING PROGRAM

MEDICAL INFORMATION:

(NOTICE: THIS IS CONFIDENTIAL INFORMATION)

Doctor's Name: _____ Doctor's Telephone: _____

Preferred Hospital: _____

Medical Insurance Company: _____

Plan/Policy Number: _____

MEDICAL QUESTIONS:

(circle one)

Are you allergic to anything? (food, plants, medicines, insect bites?) Yes / No
Do you have any serious medical problems? Yes / No
Do you have any psychiatric problems? Yes / No
Are you being treated by a doctor for anything? Yes / No
Do you take any prescription medications? Yes / No
Do you have or have had diabetes, epilepsy, convulsions, seizures or tuberculosis? Yes / No
Have you been in contact with or are you being treated for any infectious diseases? Yes / No
Do you have any heart problems, high blood pressure, or asthma? Yes / No
Have you ever been treated for cancer or leukemia? Yes / No
Have you ever been treated for kidney disease? Yes / No
Do you have hemophilia or any type of rare blood disease? Yes / No
Do you have any physical or behavioral conditions that may affect or limit full participation? Yes / No
Do you wear glasses, contacts or have had a vision corrective surgery? Yes / No
Do you have any hearing loss or are hearing impaired? Yes / No
Some activities involve extreme physical activities including being near or on/in water, or at high altitudes, high heights or around loud noises, or fast speed/movement. Do you have any diagnosed conditions or fears, that may affect or limit full participation? Yes / No
Do you know how to swim? (If Yes, circle your proficiency: Beginner, Advanced, or Lifeguard) Yes / No

If you answered "Yes" to any of the above questions, explain in detail:

IMMUNIZATIONS: (Date of last Inoculation)

Chicken Pox:	Measles:	Polio:
Diphtheria:	Mumps:	Rubella:
Hepatitis B:	Pertussis:	Tetanus Toxoid:

I am furnishing this information to be accurate to the best of my knowledge in order for medical personnel to be able to make informed medical treatments for my person.

Printed Name

Signature

Date