963 EFFECT, INC.
ADULT EMERGENCY MEDICAL CARD

Name ____
Last First Middle

Male ________ Female _________ Date of Birth _________________________

Primary Residence ____

____ Home Phone _____________________
City State Zip Code

Location of Trip ____ Trip Dates _____________________________

Emergency Contacts to call (and to whom we may release child if parents can not be reached). **Two are required**:

____ ________________________ ________________________
Name (Relationship to Applicant) Home Phone Mobile Phone

____ ________________________ ________________________
Name (Relationship to Applicant) Home Phone Mobile Phone

Physician's Name ____ Phone ___________________________

Does the applicant have any history of:

Yes No Heart Problems If yes, describe:____

Yes No Kidney Problems If yes, describe:____

Yes No Lung Problems If yes, describe: ____

Yes No Is the applicant allergic to any form of medication? List all allergies to medication and describe the reaction to the medication.

____
____

Yes No Does the applicant have any other allergies? List all allergies to foods, plants, medicines, bees, or other. Describe the reaction to this allergy and provide the medication or treatment prescribed for the allergies of this student:

____
____

Yes No Does the applicant have any health conditions or medical problems of which the team leaders should be aware? If yes, list the condition and any treatment. This may include limitations of activities, attention, or emotional concerns, special diet, etc.

____
____

Yes No Does the applicant have diagnosed asthma? If yes, list treatment prescribed (daily and for emergency).

____
____

Yes No Does the applicant take any medications daily? If yes, list the name of the medication, dosage, and reason for medication. ____
____

Yes No Does the applicant take medications often, but not daily? If yes, list the name of the medication, dosage, and reason for medication. ____
____

List any other prior injuries, illnesses, and/or surgeries, or other conditions that an EMT or other medical personnel would need to know in case of an emergency. Please tell the age of the applicant when this even occurred and if he/she required hospitalization:

Injury/Illness/Surgery ______________________________Age_______Date__________________
Injury/Illness/Surgery ______________________________Age_______Date__________________
Injury/Illness/Surgery ______________________________Age_______Date__________________
Injury/Illness/Surgery ______________________________Age_______Date__________________
Injury/Illness/Surgery ______________________________Age_______Date__________________

Authorization and Consent to Administer Over-the-Counter Medications and Medical Treatment

I authorize 963 Effect, through its appointed leaders, to administer first aid or other minor medical treatment including the above referenced over-the-counter medication(s) as shall be deemed best under the circumstances to me. I consent to receive treatment during the following trip: _______________________________________. I understand that 963 Effect will attempt to notify an emergency contact in the event of an emergency requiring immediate medical care for me. If 963 Effect is unable to speak with me or the appropriate emergency contact, I give permission for me to be treated by qualified medical personnel at an emergency clinic, hospital, or other similar medical facility. I release and hold harmless the Board of Directors, as well as any other leader associated with 963 Effect, both individually and in their official capacity(ies), from any liability for administering medications and first aid to or seeking medical care for me. I agree to indemnify and hold harmless 963 Effect, its Board of Directors and leaders, both jointly or severally, from and against any and all claims, damages, causes of action or injuries that arise from the medicating, providing first aid, or seeking emergency medical care for me while participating in the stated trip. I acknowledge that it is my responsibility to keep my records (phone numbers, work location, emergency contact, health status, and immunization records) current. I also understand that neither general medical nor accident insurance is provided by 963 Effect and that the responsibility for providing such coverage rests with me as parent/guardian for me.

Insurance Co. Name _____________________________ **Name of Insured** _______________________

Insurance Co. Address ____

ID Number ______________________________ **Group Number** ______________________________

(If applicant is not covered under an insurance plan, please write *no insurance*)

Participant's Signature____________________________ **Date** ______________________

SIGNATURE MUST BE NOTARIZED

________________________________, Notary Public

My Commission Expires___________________ SEAL

County_______________State_____________