TROOP 140

Falls Church, Virginia

EMERGENCY TREATMENT FORM

I hereby authorize any licensed physician, any physician member of Department of Emergency Medicine of a hospital, or any member of the medical staff of the hospital requested by a Department of Emergency Medicine physician to render medical treatment that in his or her judgment may be deemed necessary in the care of _____.
(Name of Scout or Scouter)

Signed: _____ Date: _____

Name: _____
(Parent or Guardian/Scouter)

Scout's/Scouter's Identification:

Name: _____ Date of Birth: _____

Address: _____

_____

Home Phone: _____ Father's Work: _____
Mother's Work: _____

Emergency Phone Number Other than Home: _____

Medical Information:

Personal Physician: _____ Phone: _____

Insurance Company: _____ I.D. #: _____

Allergies: _____

Medications Currently Taking: _____

Any Other Medical Concerns: _____

Date of Last Tetanus Shot: _____