BFM EMERGENCY HEALTH INFORMATION

Member's Name_____BirthDate:_____

Home Address _____City_____Zip_____

Home Phone _____Cell:_____email:_____

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2 Persons to contact in case of Emergency:

Name:_____phone:_____relationship:_____

Name:_____phone:_____relationship:_____

Medical Insurance:_____ Id No._____

Name of Doctor: _____Phone No._____

Is member allergic to any medications/drugs? YES_____ NO _____

If yes, what? _____

Does member have any chronic illness (e.g. asthma, migraines) YES _____ NO _____

If yes, what? _____

Does member take any medicine regularly? YES _____ NO _____

If yes, what? _____

Consent for Treatment

(I)(We), the undersigned or the parent or legal guardian of the member named above, do hereby authorize a representative of the Ballet Folklorico Mexicano as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care that is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of an accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or for payment of a physician in any case.

It is understood that the authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority ad power on the part of the above-mentioned agent(s) to give specific consent to any and all such diagnosis treatment or hospital care that the above mentioned physician in the exercise of his or her best judgment may deem advisable.

Member's (or parent) Signature: _____Date:_____

Ibfm/medical/2021