Top Teens of America

Medical Information Form

Name ______ **Chapter** ______ **Area** ______

Address ______ **City** ______ **State** ______ **Zip** ______

Email ______ **Home Ph.** ______ **Cell Ph.** ______

Current Grade Level ______ **Age** ______ **Birth Date** ______

Please list any known allergies (medication, food, etc.) and any other health problems:

Details of any of the above and another important medical information

Current medication being taken: ______

Date of last Tetanus Toxoid Injection ______ **Date of last Health Exam** ______

Insurance Carrier ______ **Policy #** ______ **Group #** ______

Name of Insured (Parent/Guardian) ______

Emergency Information

Father ______ Home Phone ______

Address ______ Cell Phone ______

Mother ______ Home Phone ______

Address ______ Cell Phone ______

Alternate Contact (if parent/guardian not available)

Name ______ Home Phone ______

Relationship ______ Cell Phone ______

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Top Teens of America

Medical Treatment Authorization Form

The undersigned parent/legal guardian of the above hereby authorizes TTA Advisor ________________________
and TLOD President _________________________________ of the _________________________ Chapter
as agents to authorize care for ____ if in the opinion of any licensed physician, surgeon, or hospital it is necessary for the treatment of the Teen in an emergency situation. Any physician, surgeon, or hospital is authorized to relay upon any authorization for treatment by the undersigned. This will remain valid and full force and effect from ________________ to _________________
The name of our physician is ____ . He/She may be reached at
HOME ___________________________________ or OFFICE ____

____ ________________________

Signature of Parent/Guardian ***Date***

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