Yeshiva of Greater Washington – Tiferes Gedaliah

EMERGENCY MEDICAL AUTHORIZATION FORM

I hereby give the authorities of Yeshiva of Greater Washington – Tiferes Gedaliah (YGW) my full consent to act on my behalf in procuring medical care for my son or daughter named below, in the event of accident or illness while s/he is a boarding student at YGW. Such care may include, but is not limited to, transportation to an emergency medical facility or physician's office or residence, blood tests, x-rays, emergency anesthesia or other necessary medications, emergency surgery if necessary to preserve life or limb, and non-emergency health care as needed for illness or injury.

Name of Student: _____

_____ _____

Parent's signature Date

State of _____ County of _____ SS:
Sworn to and subscribed before me this _____ day of _____, 20____.

_____

Notary Public, My commission expires _____

PERTINENT MEDICAL INFORMATION (allergies, asthma, diabetes, convulsions, regular medications, etc.)

_____

_____

PATIENT REGISTRATION • *Please Print Clearly*

PATIENT NAME: First	Middle	Last		DATE OF BIRTH	AGE
HOME ADDRESS	Apt. No.	CITY	STATE	ZIP CODE	
OCCUPATION	SOCIAL SECURITY NO.	MARITAL STATUS ☐S ☐M ☐D ☐W	SEX	HOME PHONE	
EMPLOYER	ADDRESS			WORK PHONE	
SPOUSE'S NAME (OR PARENT)	SPOUSE'S EMPLOYER (OR PARENT)			SPOUSE'S WORK PHONE (OR PARENT)	
SPOUSE'S OR PARENT'S ADDRESS					
NEAREST RELATIVE/FRIEND (NAME)	RELATIONSHIP	HOME PHONE		WORK PHONE	
RELATIVE/FRIEND'S ADDRESS					
REFERRING PHYSICIAN	ADDRESS			TELEPHONE	

BILLING AND INSURANCE INFORMATION

SEND BILL TO	FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	
	HOME ADDRESS	CITY	STATE	ZIP CODE
	EMPLOYER	WORK PHONE	HOME PHONE	
PRIMARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP/CODE	
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE	
	SUBSCRIBER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT	
	SUBSCRIBER'S ADDRESS	WORK PHONE	SUBSCRIBER'S DATE OF BIRTH	
SECONDARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP/CODE	
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE	
	SUBSCRIBER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT	
	SUBSCRIBER'S ADDRESS	WORK PHONE	SUBSCRIBER'S DATE OF BIRTH	

** PLEASE AFFIX A LEGIBLE COPY OF YOUR INSURANCE CARD TO THIS FORM. **