YOUNG MARINES OF THE MARINE CORPS LEAGUE
WASHINGTON DC

Young Marines
Emergency Contact and Medical Consent
PLEASE PRINT (Update Annually)

Last Name _____First Name _____Middle Initial_____

Age _____ Date of Birth ___/____/____Social Security Number_____

Home Street Address _____ City _____ State___ Zip Code _____

Parent/Guardian Name _____ Relationship _____

Home Street Address _____ City _____ State___ Zip Code _____

Home Telephone Number (____)_____ Work Telephone Number (____)_____

Mobile Number (____)_____ Pager Number (____)_____ Other Number (___)_____

ADDITIONAL EMERGENCY CONTACT (Other than parent/guardian)

Name _____ Relationship _____

Home Address _____ City _____State ____ Zip Code _____

Home Telephone Number (____)_____ Work Telephone Number (____)_____

Name _____ Relationship _____

Home Address _____ City _____State ____ Zip Code _____

Home Telephone Number (____)_____ Work Telephone Number (____)_____

MEDICAL INSURANCE INFORMATION (Please provided front & back photocopy of Insurance Card)

Name of Medical Insurance Company _____
Policy Number _____ Contact Telephone Number (___)_____

AUTHORIZATION FOR MEDICAL TREATMENT

_____ has my permission to take any Over-the-Counter Medications as
Child's Name
needed except for _____
List the Over-the-Counter Medications not to be taken
while attending a Young Marine Activity. I verify that the Young Marines have my permission to take
_____ to the nearest medical treatment facility for emergency treatment.
Child's Name

_____ _____ _____ _____
Mother/Legal Guardian Date Father/Legal Guardian Date

(YMFORM 12)