



**MEDICAL AND DENTAL INFORMATION FOR
EMERGENCY ACTION**

Name of Birthmother

Birth date

Physician to be notified in an emergency:

Name _____

Address _____

Phone _____

Dentist to be notified in an emergency:

Name _____

Address _____

Phone _____

Relative/Guardian or other person to be notified in an emergency:

Name _____

Address _____

Phone _____

Is this woman allergic to any medication? Is so, state the medication and describe symptoms below. Otherwise, state "NO" or "Unknown"

Does this woman have any significant medical problems?

_____ Yes _____ No

If yes, describe below in some detail; state each health condition or problem separately and explain its effects, duration, treatment, etc. You may use the back of this form for additional space.

Does this woman have any history of substance abuse? ____ Yes ____ No
If yes, state below each substance by name and any known facts concerning its use by the woman (length of use, treatment provided, most recent usage, etc).

Payment for the medical and/or dental services provided to this birthmother will be made by the health insurance or other means indicated below:

____ WELFARE coverage (Medicaid) # _____

____ Other Health Insurance

Company Name _____
Policy # _____ Phone () _____

Company Name _____
Policy # _____ Phone () _____

____ Other Means (please specify) _____

I consent to the performance of medical and dental treatment as deemed advisable and/or necessary in the judgment of those physicians consulted by the Home.

I consent to the performance of any obstetrical procedure as deemed necessary by the Home's obstetrician or whomever he may designate to assist him.

I consent to the performance of medical procedures and/or operations in addition to, or different from, those presently expected, whether or not arising from presently unforeseen conditions, which the above-mentioned physicians may consider advisable or necessary in the course of the medical procedures.

I consent to release all past and present medical records to A Place For Us Ministries

I absolve the Home from any and all liability which may be incurred during _____ stay.

The intent and contents of this form have been fully explained to me and I certify that I have an understanding of both.

(Cross out any of the above paragraphs that do not apply)

Signature of Birthmother _____ Date _____

Signature of Parent/Guardian _____ Date _____

Staff Signature _____