



**YOUNG MARINES OF THE MARINE CORPS LEAGUE  
WASHINGTON DC**

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

EMAIL: \_\_\_\_\_

**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 provide 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  
needed except for \_\_\_\_\_  
Child's Name \_\_\_\_\_  
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 \_\_\_\_\_