EMERGENCY MEDICAL TREATMENT

Date of Incident ______________________

Child's Name ___________________________________ DOB ___________________

Host Family Name ___________________________ Phone Number _________________

Facility Name where treatment was received ___________________________________

Address of Facility ____

City/State/Zip Code ____

Physician/Medical personnel name ____

Reason treatment was sought: *and/or attach hospital/clinic information*

Medications given/received:

Follow up treatment recommendations:

Billing Information:

Traveler's Insurance Information given	Yes____	No____	
Paid by Host Family	Yes____	No____	Amount___________
Donated Services	Yes____	No____	

Host Family:
Please fill this form out completely and mail/fax to the address below. Please send copies of any clinic/hospital documentation to:

Global Family Alliance
Attention: Carole Clark
13208 Meridian Ave N
Marysville WA 98271
Fax: 360 651-7482 Attn: Carole Clark, ARNP

Please call if you have any questions: Carole Clark 425 931-8459

5/08 clark

Office use only
Receipts received________
Date forwarded to bookkeeper________
Date forwarded to Ins. Coordinator________