EMERGENCY MEDICAL AUTHORIZATION FORM

PARTICIPANT'S INFORMATION:

Last: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work: _____ Cell:_____

Date of Birth: _____

Medical Insurance Company: _____ Phone:_____

Policy Holder's Name: _____

Policy #: _____ Group #: _____

MEDICAL INFORMATION

Doctor: _____ Phone:_____

Dentist: _____ Phone:_____

Allergies: _____

Current Medications: _____

Medical Conditions: _____

PRIMARY EMERGENCY CONTACT - PARENT/GUARDIAN/SPOUSE (IF APPLICABLE)

Name _____ Relationship: _____

Phone: _____ Cell: _____

ALTERNATE EMERGENCY CONTACT

Name _____ Relationship _____

Phone _____ Cell: _____

PART I OR II *(not both)* MUST BE COMPLETED

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: 1) the administration of any treatment deemed necessary by a licensed physician or dentist; and 2) the transfer of myself/my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____

Printed Name of Participant (INCLUDE NAME OF Parent/Guardian if under 18)

_____

Signature of Participant (Or Parent/Guardian if under 18)

Date: _____

ADDITIONAL INFORMATION:

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of myself/my child. In the event of illness or injury requiring emergency treatment, I wish the responders to take the following action:

_____

_____

_____

_____

_____

_____

_____

Printed Name of Participant (INCLUDE NAME OF Parent/Guardian if under 18)

_____

Signature of Participant (Or Parent/Guardian if under 18)

Date: _____