EMERGENCY MEDICAL AUTHORIZATION

Name: Date:

Address Phone:

City: State: Zip:

Preferred Physician Phone:

Office Address

Preferred Hospital Phone:

Office Address

Preferred Dentist Phone:

Office Address

Please list any facts concerning individual's medical history, including allergies, medication being taken, and physical impairments to which a physician should be alerted:

AUTHORIZATION OF TREATMENT

In case of emergency contact one of the following:

Name: Phone:

Name: Phone:

In the event that resonable attempts to contact the above have been unsuccessful, I herby give my consent for the administration of any treatment deemed necessary by a licensed physician or dentist or the transfer to any hospital reasonably accessible.

Signature Date:

(Parent/Guardian's signature if participant is under the age of 18)