

INSERT CHURCH
LOGO HERE

EMERGENCY MEDICAL AUTHORIZATION

Insert Church Name Here

INSERT CHURCH CONTACT INFO HERE

Name	Date
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Address	Phone
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City	State	Zip
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Preferred Physician	Phone
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Office Address

Preferred Hospital	Phone
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Office Address

Preferred Dentist	Phone
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Office Address

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

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AUTHORIZATION OF TREATMENT

In case of emergency contact one of the following:

Name	Phone
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Name	Phone
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In the event that reasonable attempts to contact the above have been unsuccessful, I hereby 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
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Parent/Guardian's signature if participant is under the age of 18	Date
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