Emergency Medical Form

Name_____

Address_____

City _____**State**_____ **Zip**_____

Home number: _____ **Cell phone:** _____

Email: _____

Date of Birth: _____

Medical Problems or Concerns:

_____

_____

Medications:

_____

_____

_____

_____

Allergies:

_____

_____

_____

Emergency Contacts

Name: _____ **Phone #:** _____
Relationship:
_____

Name: _____**Phone#:** _____
Relationship:
_____

Name: _____**Phone:** _____
Relationship:
_____

Consent Form

I hereby give my consent for

1: the administration of any treatment deemed necessary by

Preferred Physician:

_____
_____
_____

Preferred Dentist:

_____
_____
_____

Or in the event the designated preferred physician/dentist is not available, by another licensed physician/dentist.

2: and the transfer of the _____ to and treatment by _____ (preferred hospital) or any other hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians, concurring in the necessity for such surgery are obtained before the surgery is preformed.

Medical Insurance:

_____

Identification Number:

_____

Signature: _____ Date: _____

Please attach a copy of you insurance card to this form