Emergency Medical Authorization Form

Participant Information

Full Name

Date of Birth

Gender

Address

Parent/Guardian Name (if under 18)

Contact Phone 1

Contact Phone 2

Medical Information

Primary Physician Name

Physician Phone

Insurance Company

Policy Number

List known allergies

List current medications

List known medical conditions

Emergency Contact

Contact Name

Relationship

Contact Phone

Authorization & Consent

I hereby give permission for emergency medical treatment to be administered to the participant named above if necessary. I understand every effort will be made to contact me, but if I cannot be reached, I authorize appropriate medical care.

Signature

Date