Medical Consent Authorization

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Medical Provider Information:

Insurance Provider: _____ Policy Number: _____

Physician: _____ Physician's Phone: _____

Text

Physician's Address:

In Case of an Emergency Contact:

_____

Name Phone Relationship

_____

Name Phone Relationship

Known Medical Problems and Medications:

This information is included to provide information to emergency personnel of medical problems and medications in an emergency situation.

Existing Medical Problem *(Example: Asthma)*	**Medication Taken** *(Example: Combivent)*	**Dosage Taken** *(Example: 2 puffs)*	**Dosage Frequency** *(Example: "Twice Daily")*

Medical Consent Authorization:

In the event of an injury, accident, illness or other emergency, and if the above stated physician cannot be reached, I authorize ____ myself _____ my child to be treated by certified emergency personnel such as emergency medical technicians, emergency room physicians and other emergency room personnel such as nurses and laboratory technicians. I agree to accept financial responsibility for the costs related to this medical treatment.

_____

Name Phone Date Signed

_____

Name of Authorized Parent or Guardian Phone Date Signed

Note: This form is designed to present general consent for emergency medical treatment and may not include all the requirements of your state. You should consult with a legal professional to ensure that all of your medical, legal and financial rights are protected.