EMERGENCY MEDICAL AUTHORIZATION PERMIT

Name (please print) _____ Phone Number _____

_____ Date of Birth _____

Address _____

Should I become incapacitated and unable to authorize the delivery of emergency medical care, diagnosis, and treatment, including surgical intervention, if necessary, I authorize the individuals listed below to act on my behalf.

This authorization shall remain valid until such time as I withdraw the authorization.

Authorized Person #1_____ Phone Number_____

Authorized Person #2_____ Phone Number_____

Preferred Physician_____ Phone Number_____

Address_____

Preferred Dentist_____ Phone Number_____

Address_____

Insurance Carrier_____ ID number_____

Allergies_____

Current Medications/Treatments_____

_____

Please list any other necessary medical information_____

_____

Signature _____ Date _____