Emergency Medical Procedure Consent Form

Patient Information

Patient Name

Date of Birth

Address

Phone Number

Emergency Contact Name

Emergency Contact Phone

Consent

I hereby authorize the medical and hospital staff to perform emergency medical procedures and provide treatment as deemed necessary for my health and well-being (or that of the person named above) in the event of a medical emergency.

Known Allergies (if any)

Pre-existing Medical Conditions

Current Medications

Additional Instructions / Notes

Authorization

I have read and understand the above information. By signing below, I give my consent for emergency medical treatment.

Patient or Legal Guardian Signature

Date

This consent form is valid until revoked in writing.