Emergency Medical Consent Form

Patient Information

Full Name

Date of Birth

Address

Phone Number

Guardian or Parent Information (if under 18)

Name

Relationship to Patient

Phone Number

Consent Statement

In the event of a medical emergency, I hereby authorize qualified medical professionals to administer medical treatment and necessary procedures to the above-named person. I understand every effort will be made to contact me prior to such action.

Medical Information

Known Allergies

Current Medications

Primary Physician

Physician Phone

Signature

Date

Witness Signature

Date