

Emergency Medical Treatment Authorization Waiver

Participant Information

Full Name:

Date of Birth:

Parent/Guardian Name (if under 18):

Address:

Phone Number:

Emergency Contact Name:

Emergency Contact Phone:

Medical Information

Allergies / Medical Conditions:

Current Medications:

Health Insurance Provider:

Policy Number:

Authorization and Consent

I, the undersigned, hereby authorize and consent to emergency medical treatment, hospitalization, or other medical procedures as may be deemed necessary for the participant named above by qualified medical personnel. I understand that reasonable efforts will be made to contact me prior to treatment, but I authorize treatment if I cannot be reached.

Signature:

Date: