EMERGENCY MEDICAL AUTHORIZATION PERMIT

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

This authorization is valid until such time as I withdraw the authorization.

Authorized Person _____

Telephone Number _____

Authorized Person _____

Telephone Number _____

Doctor Preferred _____ Telephone _____

Doctor's Address _____

Dentist Preferred _____ Telephone _____

Dentist's Address _____

Insurance Company _____ I.D. No. _____

Important Medical Information:

Allergies _____

Current Medications or Treatments _____

_____

Previous Operations or Hospital Confinements _____

_____

_____

Other: _____

_____ _____
Name (Print or type) Date of Birth

_____
Number Street Apt. # City Sate Zip

_____ _____
Signature Date