

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 State Zip

Signature

Date