# Emergency Medical Authorization Form

**PART I.** The purpose of this form is to authorize the provision of emergency treatment for chapter members in the unlikely event that they become ill or injured while traveling with their advisor. It is imperative the following information be furnished so that the member will be cared for properly. The authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

*Please print neatly and use black ink.*

I, _____ of _____

Member member name — Street, City, State, ZIP Code

hereby give my consent for (1) the administration of any emergency treatment deemed necessary by a licensed physician or dentist, (2) the transfer to any hospital reasonable accessible, and (3) consent to release the medical information provided.

| | |
|---|---|
| Member signature | Date (month/day/year) |
| Parent or guardian signature (if member is under age 18) | Date (month/day/year) |
| Parent or guardian name (printed) | Parent or guardian phone (including area code) |
| Alternate contact name | Alternate contact phone (including area code) |

The information below is needed by any hospital or practitioner not having access to the member's medical history. **If any item is marked "Yes", please explain in the right-hand column.** If taking medication, include the name, dosage amount, and the time it is taken.

| | | |
|---|---|---|
| **Allergies**<br>Food<br>Medications<br>Other (insects, etc.) | ☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No | |
| **Health problems or physical disabilities** | ☐ Yes ☐ No | |
| **Respiratory problems** | ☐ Yes ☐ No | |
| **Diabetes** | ☐ Yes ☐ No | |
| **Epilepsy** | ☐ Yes ☐ No | |
| **Chronic disease** | ☐ Yes ☐ No | |
| **Emotional or psychological problems** | ☐ Yes ☐ No | |
| **Current medications** | ☐ Yes ☐ No | |
| **Eyeglasses:** ☐ Yes ☐ No **Contact lenses:** ☐ Yes ☐ No **Hearing devices:** ☐ Yes ☐ No | | |
| **Required immunizations up to date?** ☐ Yes ☐ No **Date of last tetanus booster:** | | |

# Refusal of Consent

**NOTE: Do not complete this form if you completed Part I.**

**PART II.** *Please print neatly and use black ink.* I do not give my consent for emergency medical treatment. In the event of illness or injury requiring emergency treatment, I wish the authorities to take no action or to:

_____

_____

| | |
|---|---|
| Member name (printed) | Street, City, State, ZIP Code |
| Member signature | Date (month/day/year) |
| Parent or guardian signature (if member is under age 18) | Date (month/day/year) |
| Parent or guardian name (printed) | Parent or guardian phone (including area code) |