Emergency Medical Form ADULT

An EMF is required for each participant in MUMC trips. ***Type or print in ink completing BOTH sides.***

PARTICIPANT INFORMATION

Name:____ Date of Birth:____________________

Address:_________________________________ City:_________________ State:____ Zip Code:_______

Email:____

Daytime phone:____________________________ Evening phone:_______________________________

Cell phone:____ May we TEXT? Y N

Emergency Contact Person

Name:____ Relationship to participant:______________

Email:____

Address:_________________________________ City:_________________ State:____ Zip Code:_______

Daytime phone:____________________________ Evening phone:_______________________________

Cell phone:____ May we TEXT? Y N

Emergency Medical Information

Physical conditions such as disabilities, recurring illness, allergies (ie: dairy, nuts, seafood, insects, animals):

____

____

Date of last Tetanus Shot: ________________________________

List all medications currently being taken:____

____

____

Emergency Medical Authorization Information

Insurance Company:____

Policy Subscriber's Name:____

Policy Number:________________________________ Group Number:___________________________

____
Name of Family Physician Phone

____
Name of Medical Specialist Phone

____
Name of Dentist Phone

____
Preferred Hospital Phone

Emergency Medical Authorization (Part I or Part II Must Be Completed)

Part I (To Grant Consent)

In the event that reasonable attempts to obtain my consent have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-mentioned doctor/medical specialist/dentist or, in the event the designated practitioner is not available, by any other licensed physician or dentist; and (2) my transfer to the preferred hospital or, any hospital reasonably accessible.

I understand that the consent and authorization herein granted do not include major surgical procedures unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider.

____
Signature Date

Facts concerning my medical history and physical impairment to which a physician should be alerted:

____

____

Part II (Refusal to Consent)

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

I do not give consent for my emergency medical treatment. In the event of illness or injury, I do not give the attending physician permission to administer treatment until the emergency contact or designated individual is contacted.

____
Signature Date