APPOINTMENT OF AGENT FOR AUTHORIZATION FOR MEDICAL TREATMENT – Adult Form

I, the undersigned, hereby appoint ____ as agent to authorize, in my behalf, emergency medical/surgical treatment, including hospitalization, in the event I am unable to do so and which, in the opinion of any licensed physician, surgeon or hospital, is reasonably required or necessary for my treatment or care. Any physician, surgeon or hospital is authorized to rely upon any authorization for treatment signed by the above designated agent(s) to the same extent as if executed personally by me.

This appointment will remain valid and in full force and effect from _______________ to _______________

My personal insurance carrier is __________________________________ Policy # ________________

The name of my physician is ____

He/She may be reached at (___) ____
(Phone) (Address)

EMERGENCY INFORMATION

____ ______________________
Name of Next of Kin #1 Relationship
____ (___) _________________
Mailing Address Home Telephone
____ (___) _________________
City State Zip Business Telephone

____ ______________________
Name of Next of Kin #2 Relationship
____ (___) _________________
Mailing Address Home Telephone
____ (___) _________________
City State Zip Business Telephone

If neither of the above can be reached, you should call:

Name ____ Relationship _____________

Telephone (Home) (___) _________________________ (Business) (___) ________________________

____
Signature

(Complete both pages of this form)

STATE OF ______________________________, ________________________________ COUNTY

BE IT REMEMBERED, that on this _______ day of ________________, 20____ before me, a Notary Public, in and for the County and State aforesaid, came ____, to me personally known to be the same person who executed the foregoing instrument, and duly acknowledged the execution of the same. IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my official seal, the day and year last above written.

____
Notary Public

My appointment expires: ____________________

EMERGENCY AUTHORIZATION

I hereby give my permission to authorize emergency medical treatment in the event of my injury/illness. The health care provider is authorized to perform emergency medical services upon consent of my authorized agent as named on the reverse side of this document, if I am unable to do so.

MEDICAL INFORMATION

Check all conditions which apply. Give specific cause of allergies and any special medical information that applies.

ALLERGIES:

Drugs ______________________

Food ______________________

Hay Fever ______________________

Insect Stings ______________________

Poison Ivy ______________________

DATE OF LAST:

Tetanus toxoid immunization ______________

Health Exam ______________________

CHRONIC/RECURRING ILLNESSES:

Asthma ______________________

Diabetes ______________________

Ear Infections ______________________

Epilepsy ______________________

Heart ______________________

List any other current/recurring illness(es):

____

____

PHYSICAL LIMITATIONS: ______________________

MEDICATION AUTHORIZATION

I take the following medications:

Name of Drug(s)	Reason	Dosage

* *

I certify that all of the above information is correct.

______________________ ______________________

Signature Date

(Complete both pages of this form)