Emergency Information and Authorization for Treatment

(Dates Effective: This release shall remain in effect until revoked in writing.)

Person covered by authorization:

Name (first) (middle) (last) ______________________ Date of Birth ______________________

Spouse's Name or Parents' Names ______________________ Home Phone ______________________

Address ______________________ Work Phone - father or spouse ______________________

City Zip ______________________ Work Phone - mother (if applicable) ______________________

Emergency Information:

Emergency Contact Person (relationship) ______________________ Business Phone ______________________

Address ______________________ Home Phone ______________________

Physician's Name ______________________ Office Phone ______________________

Address ______________________ Medical Plan and Number ______________________

Medical History:

Any special medical problems or allergies: ____

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Date of last tetanus: ____

Current Medications ____

Authorization:

I, ________________________________, the adult covered by this authorization and listed above, or

I, ______________________________, the undersigned parent of _____________________________, a minor,

do hereby authorize Leslie Carmichael, or any other adult acting on behalf of the United Methodist Church of Los Altos as agent(s) for the undersigned, to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s), especially in case of emergency, to give specific consent to any such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his or her best judgment may deem advisable.

Signature(s) ____ Date ___________________