

Draft Medical Form You May Wish to Use

EMERGENCY MEDICAL AUTHORIZATION

Please **PRINT** and use **BLACK** ink.

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.

I, _____ of _____,
(Name) (Address) (City) (State, Zip)

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 reasonably accessible, and (3) consent to release the medical information provided.

_____ Date ____/____/____
(Member's Signature) (Month) (Day) (Year)

_____ Date ____/____/____
(Parent's or Guardian's Signature (Month) (Day) (Year)
if member is under 18 years of age)

The following information is needed by any hospital or practitioner not having access to the member's medical history:

Does the member have:

ANY ITEMS MARKED "YES" SHOULD BE EXPLAINED BELOW

- | | | |
|---|-----------------|----------------|
| 1. Any allergies | | |
| FOOD | _____ YES _____ | _____ NO _____ |
| MEDICATION | _____ YES _____ | _____ NO _____ |
| OTHER (insect, etc.) | _____ YES _____ | _____ NO _____ |
| 2. Any health problems or physical disabilities | _____ YES _____ | _____ NO _____ |
| 3. Any respiratory problems | _____ YES _____ | _____ NO _____ |
| 4. Any diabetes | _____ YES _____ | _____ NO _____ |
| 5. Any epilepsy | _____ YES _____ | _____ NO _____ |
| 6. Any chronic disease | _____ YES _____ | _____ NO _____ |
| 7. Any emotional or psychological problems | _____ YES _____ | _____ NO _____ |

8. Any medication being taken at present _____ YES _____ NO

9. Any Glasses YES/NO , Contact Lenses YES/NO , Hearing Devices YES/NO worn?

If any of the previous questions are marked "YES," please explain. If taking medication, please give name, amount of dosage, and time medication is taken.

10. Date of last tetanus booster: _____/_____/_____
(Month) (Day) (Year)

11. Does member have all required immunization shots? _____ YES _____ NO

PART II-REFUSAL OF CONSENT
DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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's Signature) Date _____/_____/_____
(Month) (Day) (Year)

(Parent's or Guardian's Signature Date _____/_____/_____
if member is under 18 years of age) (Month) (Day) (Year)

(Member's Name) (Street Address)

(City) (State) (Zip)