EMERGENCY MEDICAL CONSENT FORM

Please fill out this form to provide emergency medical consent

Patient Information			
First Name	**Last Name**	**Date of Birth**	
Home Phone Number	**Cellphone Number**	**Email Address**	
Street Address	**City**	**State**	**Zip Code**

Emergency Information			
First Name		**Last Name**	
Phone	**Email Address**	**Relationship to patient**	
Street Address	**City**	**State**	**Zip Code**

Primary Physician	
Physician Name	
Office Address	
Office Phone Number	

Medical History	
Existing medical conditions or allergies?	
If yes, please describe below:	
Are you currently taking any medications?	
If yes, please list below with dosage amount:	

I, , understand and acknowledge that I am voluntarily granting consent for emergency medical treatment in the event that I am unable to provide consent due to my medical condition, injury, or incapacitation. I recognize that this consent is given without coercion, and I authorize healthcare providers to administer necessary medical care, including but not limited to medical examination, diagnostic tests, surgical procedures, medications, and anesthesia.

I also understand that healthcare providers will make reasonable efforts to contact my emergency contact person listed above to inform them of the situation. I confirm that the medical information provided on this form is accurate to the best of my knowledge.

Signature Date: **Signature:**