EMERGENCY MEDICAL AUTHORIZATION

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

Part 1

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 if member is under 18 years of age) (Month) (Day) (Year)

_____ Parent's or Guardian's Phone (___)_____
(Parent's or Guardian's Name) (Area)

_____ Alternative Contact's Phone (____)_____
(Alternative Contact's Name) (Area)

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 above 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:_____

_____

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

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

_____ Parent's or Guardian's Phone (___)_____
(Parent's or Guardian's Name) (Area)

_____, _____
(Member's Name) (Street Address)

_____
(City) (State) (Zip)