EMERGENCY MEDICAL AUTHORIZATION

Southwinds Church
Tracy, California
Summer Outreach

Name	Date	
Address	Phone	
City	State	Zip
Preferred Physician	Phone	
Office Address		
Preferred Hospital	Phone	
Hospital Address		
Preferred Dentist	Phone	
Office Address		
Please list any facts concerning individual's medical history, including allergies, medication being taken, and any physical impairments to which a physician should be alerted.		
AUTHORIZATION OF TREATMENT		
In case of emergency contact one of the following:		
Name	Phone	
Name	Phone	
In the event that reasonable attempts to contact the above have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by a licensed physician or dentist or the transfer to any hospital reasonably accessible.		
Signature	Phone	
Parent/Guardian's signature if participant is under the age of 18	Phone	