

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: