

### APPOINTMENT OF AGENT FOR AUTHORIZATION FOR MEDICAL TREATMENT

I, the undersigned, hereby appoint \_\_\_\_\_ as agent to authorize, in my behalf, emergency medical/surgical treatment, including hospitalization, in the event I am unable to do so and which, in the opinion of any licensed physician, surgeon or hospital, is reasonably required or necessary for my treatment or care. Any physician, surgeon or hospital is authorized to rely upon any authorization for treatment signed by the above designated agent(s) to the same extent as if executed personally by me.

This appointment will remain valid and in full force and effect from \_\_\_\_\_ to \_\_\_\_\_

My personal insurance carrier is \_\_\_\_\_ Policy # \_\_\_\_\_

The name of my physician is \_\_\_\_\_

He/She may be reached at (\_\_\_\_) \_\_\_\_\_ (Phone) (Address) \_\_\_\_\_

#### EMERGENCY INFORMATION

Name of Next of Kin #1 \_\_\_\_\_ Relationship \_\_\_\_\_

Mailing Address \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Telephone \_\_\_\_\_

Business Telephone \_\_\_\_\_

Name of Next of Kin #2 \_\_\_\_\_ Relationship \_\_\_\_\_

Mailing Address \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Telephone \_\_\_\_\_

Business Telephone \_\_\_\_\_

If neither of the above can be reached, you should call:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone (Home) (\_\_\_\_) \_\_\_\_\_ (Business) (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
Signature

**(Complete both sides of this form)**

STATE OF \_\_\_\_\_, \_\_\_\_\_ COUNTY

BE IT REMEMBERED, that on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ before me, a Notary Public, in and for the County and State aforesaid, came \_\_\_\_\_, to me personally known to be the same person who executed the foregoing instrument, and duly acknowledged the execution of the same. IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my official seal, the day and year last above written.

\_\_\_\_\_  
Notary Public

My appointment expires: \_\_\_\_\_

**Appointment of Agent for Authorization for Medical Treatment**

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**EMERGENCY AUTHORIZATION**

I hereby give my permission to authorize emergency medical treatment in the event of my injury/illness. The health care provider is authorized to perform emergency medical services upon consent of my authorized agent as named on the reverse side of this document, if I am unable to do so.

**MEDICAL INFORMATION**

Check all conditions which apply. Give specific cause of allergies and any special medical information that applies.

**ALLERGIES:**

Drugs \_\_\_\_\_  
Food \_\_\_\_\_  
Hay Fever \_\_\_\_\_  
Insect Stings \_\_\_\_\_  
Poison Ivy \_\_\_\_\_

**CHRONIC/RECURRING ILLNESSES:**

Asthma \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Ear Infections \_\_\_\_\_  
Epilepsy \_\_\_\_\_  
Heart \_\_\_\_\_

**DATE OF LAST:**

Tetanus toxoid immunization \_\_\_\_\_  
Health Exam \_\_\_\_\_

List any other current/recurring illness(es):

\_\_\_\_\_  
\_\_\_\_\_

**PHYSICAL LIMITATIONS:**

\_\_\_\_\_

**MEDICATION AUTHORIZATION**

I take the following medications:

Name of Drug(s)	Reason	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

\*\*\*\*\*

I certify that all of the above information is correct.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**(Complete both sides of this form)**