SWO Purity Retreat

EMERGENCY MEDICAL AUTHORIZATION AND RELEASE OF LIABILITY

Name of Participant: _____ Age_____ Gender_____

Participant Signature: _____

Parent/Guardian Signature _____
(if participant not 21 years of age or older)

Emergency Contact _____
(if different than above)

Address _____

_____

Phone (____) ____ - _____ (____) ____ - _____

In the event reasonable attempts to contact the above have been unsuccessful, I hereby grant my consent for 1) the administration of any treatment deemed necessary by the following medical providers, or in the event the designated providers are not available, by another licensed physician or dentist, and 2) the transfer of the participant to said provider or medical facility.

This authorization does not cover major surgery unless the medical opinions of two or more licensed physicians or dentists concur in the necessity of such surgery prior to its performance.

I give consent for the following medical care providers and preferred local hospital to be contacted:

Physician Name _____

Address: _____

Phone #'s (____) ____ - ____

Dentist Name _____

Address _____

Phone #'s (____) ____ - ____

Preferred Hospital _____

Address: _____

Phone #'s (____) ____ - ____

Please list any facts concerning the Participant's medical history, medical conditions and/or any physical impairment to which the Church and any treating physicians should be alerted. Also include any and all known allergies and medications being taken. Please use the back if additional space is needed.

Information _____

_____

(over)

Do you have health insurance? Yes _____ No _____

Insurance Company: _____

Member ID: _____Group # _____ Phone #: _____