



## Emergency Medical Form

An EMF is required for each participant in Occupy trips. Print in ink completing both sides.

### Participant Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_  
Daytime phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_

### Emergency Contact Person

Name: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_  
Email: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Daytime phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_ May we TEXT? Y N

### Emergency Medical Information

Physical conditions such as disabilities, recurring illness, allergies (ie: dairy, nuts, seafood, insects, animals):

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Date of last Tetanus Shot: \_\_\_\_\_

List all medications currently being taken:

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**Emergency Medical Authorization Information**

Insurance Company: \_\_\_\_\_

Policy Subscriber's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

\_\_\_\_\_  
Name of Family Physician Phone

\_\_\_\_\_  
Name of Medical Specialist Phone

\_\_\_\_\_  
Name of Dentist Phone

\_\_\_\_\_  
Preferred Hospital Phone

**Emergency Medical Authorization (Part I or Part II Must Be Completed)**

**Part I (To Grant Consent)**

In the event that reasonable attempts to obtain my consent have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-mentioned doctor/medical specialist/dentist or, in the event the designated practitioner is not available, by any other licensed physician or dentist; and (2) my transfer to the preferred hospital or, any hospital reasonably accessible.

I understand that the consent and authorization herein granted do not include major surgical procedures unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider.



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Signature

Date

Facts concerning my medical history and physical impairment to which a physician should be alerted:

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**Part II (Refusal to Consent)**

**DO NOT COMPLETE PART II IF YOU COMPLETED PART I**

I do not give consent for my emergency medical treatment. In the event of illness or injury, I do not give the attending physician permission to administer treatment until the emergency contact or designated individual is contacted.

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Signature

Date