

MEDICAL AUTHORIZATION
EMERGENCY ROOM - CONSENT TO TREAT

It is recommended that a duplicate copy be kept for future reference. It is the responsibility of the parent or guardian to notify the hospital keeping this record should changes occur in the following information:

Permission is given to any available physician, or member of a hospital medical staff to perform emergency treatment, and procedures for _____ as he/she deems necessary, and to continue treatment and procedures until such time as the undersigned shall dismiss him/her or engage another physician. This permission includes admission to one of the local hospitals, if the attending physician deems it necessary.

Signed: _____

Relationship: _____

_____ Witness

_____ Witness

_____ Date

PLEASE ANSWER THE FOLLOWING QUESTIONS:

KNOWN ALLERGIES

MEDICAL PROBLEMS

DATE OF LAST TETANUS BOOSTER _____

MEDICATIONS CURRENTLY BEING USED

DOCTOR PREFERRED _____

HOSPITAL PREFERRED _____

CONSENT VALID UNTIL _____

BIRTHDATE _____

INSURANCE _____

HOME PHONE _____

BUSINESS PHONE _____

*Please mail this application, sponsor endorsement, medical release and a \$10 deposit to
Yellowstone Chrysalis Community P.O. Box 23593 Billings MT 59104