Medical Consent and Permission to Treat

(Adult Form-Valid for one year from date signed)

Name: _____

Home Address: _____

City State Zip

Home Phone: (___) _____Cell Phone: (___) _____

Email Address: _____ Shirt Size: _____

To the best of my knowledge, I am in good health, and assume all responsibility for my health.

In the event of an emergency, I give permission for myself to be transported to a hospital for emergency treatment. Please advise _____ prior to any further treatment by the hospital or doctor.

Emergency Contacts

Name: _____Relationship to me:_____

Address (if different from above):_____

City State Zip

Home Phone: (___) _____Cell Phone: (___) _____

If above named person is unable to be reached, please contact:

Name: _____Relationship to me:_____

Address (if different from above):_____

City State Zip

Home Phone: (___) _____Cell Phone: (___) _____

Please include a photocopy of your insurance card, front and back.

Insurance carrier: _____ Policy Number: _____

I am taking he following medication(s) and directions for taking this medication, including dosage, frequency and storage are as follows: _____

_____

I am allergic to the following: _____

My immunizations are current and up to date: ___Yes ___No

I have the following limitations:_____

_____

Signature: _____ Date: _____