EMERGENCY MEDICAL CONSENT FORM

Member's Name___________________________________

Member's Date of Birth _______ / _______ / ________

Phone Numbers where parents/emergency contact can be reached:

Home________________Work ___________________

Cell _________________ Other ___________________

Specify any medical conditions of which an attending physician should be made aware (include all medications taken regularly, including dosages):

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Insurance Information:

Name of Policy Holder ____

Insurance Company Policy Number _________________Group Number _________________

Consent:

If deemed necessary by the Directors during a LINEA function, permission is here by granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations, and immunizations for the above-named member. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way. If said physician is not able to communicate with me, the treatment necessary for the best interest of the member may be given.

Signature of Member ____Date

Signature of Parent/Guardian (IF UNDER 18) ________________________________Date