ALABAMA WEST FLORIDA CONFERENCE
UNITED METHODIST WOMEN HEALTH FORM
For the Calendar Year 2017
Authorization for Emergency Medical Treatment Form

Name	DOB

Home Phone	Work #	Cell #

Physician's Name	Phone #

Health Insurance Company	Policy #	Group #

Allergies to medications:

Other Allergies (food, animals)

Conditions that treating personnel might need to be aware of:

In the event emergency medical aid/treatment is required due to illness or injury during my stay at a UMW event, I authorize ALWF UMW to:

Name	Relation	Phone #	Alt. Phone #

Name	Relation	Phone #	Alt. Phone #

PLEASE CHECK ONE OF THE BELOW PLANS

☐ **Consent Plan**

In the event emergency medical aid/treatment is required due to illness or injury during my stay at a UMW event. I authorize ALWF UMW to:

1. Secure and retain medical treatment and transportation if needed.
2. Release my health information to the authorized individual or agency involved in the medical emergency treatment.
3. I hold harmless the AL-WFL Conference United Methodist Women, the ALWF Conference, The United Methodist Church and/or the owners of the facility for which the event is taking place for any act or failure to act during a medical emergency.

☐ **Non-Consent Plan**

I DO NOT give my consent for emergency medical treatment/aid in the cases of illness or injury. In the event emergency treatment/aid is required, I wish the following procedures to take place:

I hold harmless the AL-WFL Conference United Methodist Women, the ALWF Conference, The United Methodist Church and/or the owners of the facility for which the event is taking place for any act or failure to act during a medical emergency.

Your Consent Signature	Date

Witness Signature	Date