

ALABAMA WEST FLORIDA CONFERENCE UNITED METHODIST WOMEN HEALTH FORM

For the Calendar Year

2018

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