Authorization for Emergency Medical Treatment

In the event emergency medical aid / treatment is required due to illness or injury during the process of participating in programs, activities or receiving other services, I hereby authorize the Town of Matthews Parks, Recreation and Cultural Resource Department to:

- Secure and retain medical treatment and transportation if needed.
- Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant's Name: Date of Birth:

Address: City / State / Zip Code:

Parent / Guardian's Name(s): Phone Number:

Phone Number: Phone Number:

In the event I / We cannot be reached, contact:

Name Phone Number:

Name Phone Number:

Physician's Name: Phone Number:

Preferred Hospital:

Health Insurance Company: Policy Number:

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the persons identified above are unable to be reached.

Parent / Guardian Name (printed):

Consent Signature of Parent / Guardian:

Date:

Non-Consent Plan

I do not give consent for emergency medical treatment / aid in the case of illness or injury during the process of participating in programs, activities or receiving other services. In the event emergency treatment / aid is required, I wish the following procedures to take place:

Parent / Guardian Name (printed):

Non-Consent Signature of Parent / Guardian:

Date: