EMERGENCY MEDICAL TREATMENT

The purpose of providing the following information is to assist Pitzer College in the event of an emergency medical situation during your voluntary participation in _____. Please fill out the requested information completely and list any additional information that may be important should an illness or injury occur, including but not limited to medication allergies and all medications currently used. Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

In case of an emergency involving _____ ("Participant"), I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the Pitzer College faculty/staff member in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for Participant. In addition, medical providers are hereby authorized to disclose to Pitzer College faculty/staff member in charge Protected Health Information/Confidential Health Information (PHI/CHI), including examination findings, test results, and treatment provided, for purposes of treatment of the participant, follow-up and communication with the Participant's emergency contact(s).

This authorization shall be in force and effect for six months, or until revoked by me, in writing, by sending such written notification to_____ and/or any medical providers providing emergency medical treatment. I understand that a revocation is not effective to the extent that medical providers providing emergency medical treatment or Pitzer College have relied on the use or disclosure of the medical information provided.

I accept responsibility for the payment of all services rendered.

☐ Without restrictions.

☐ With special considerations or restrictions (list): _____

_____

Medication allergies:_____

Currently used medications:_____

_____

Additional important information should an injury or illness occur _____

_____

* * * * * * * * * * * * *

Please print legibly:

IN CASE OF EMERGENCY NOTIFY:

Name _____ Relationship _____

Address _____ City, State, Zip _____

Please check one box for primary phone number:

Hm Ph: ☐ _____ Bus. phone: ☐ _____Cell phone: ☐ _____

INSURANCE INFORMATION:

Insurance Provider _____ Plan/Coverage _____

Subscriber _____

Group/Plan# _____	ID# _____

I have read this document, and I am signing it freely. No other representations concerning the legal effect of this document have been made to me.

Participant's name _____

Participant's signature _____

Parent/Guardian signature *(if under 18)* _____

Date_____