EMERGENCY MEDICAL AUTHORIZATION

The purpose of this form is to authorize the provision of emergency treatment for delegates who become ill or injured while on official travel for Business Professionals of America. It is imperative the following information be furnished to Business Professionals of America so that the delegates will be cared for properly. The authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Address) (City, State, Zip)

hereby give my consent for (1) the administration of any emergency treatment deemed necessary by a licensed physician or dentist, (2) the transfer to any hospital reasonably accessible, and (3) consent to release the medical information provided.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Delegate’s Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent’s/Guardian’s Signature if delegate is under 18 years old)

Day Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information is needed by any hospital or practitioner not having access to the delegate’s medical history:

ANY ITEMS MARKED “YES” SHOULD BE

Does the delegate have: EXPLAINED BELOW

1. Any Allergies

FOOD \_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_NO

MEDICATION \_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_NO

OTHER (insect, etc.) \_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_NO

2. Any Health, Physical Handicaps or Problems \_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_NO

3. Any Respiratory Problems \_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_NO

4. Any Diabetes \_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_NO

5. Any Epilepsy \_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_NO

6. Any Chronic Disease \_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_NO

7. Any Emotional or Psychological Problems \_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_NO

8. Any Medication Being Taken at Present \_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_NO

9. Any Glasses YES/NO, Contact Lenses YES/NO, Hearing Devices YES/NO worn?

If any of the above questions are marked “YES” please explain, and if taking medication please give name, amount of dosage and time medication is taken.

10. Date of last tetanus booster \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_.

(Month) (Day) (Year)

11. Does delegate have all required immunization shots? \_\_\_\_\_\_YES \_\_\_\_\_\_NO