WAYNE COUNTY COMMUNITY COLLEGE DISTRICT
SCHOOL OF CONTINUING EDUCATION

ADULT STUDENT
EMERGENCY MEDICAL TREATMENT RELEASE FORM

I, _____hereby authorize emergency medical treatment for myself. I understand that this treatment will be administered by a qualified and licensed healthcare professional when, in the opinion of the attending healthcare professional, undue delay may endanger my life, or cause disfigurement, physical impairment, or unreasonable discomfort. This authority is granted only after a reasonable effort to reach my emergency contact at the contact numbers provided below has failed.

Emergency Contact # :_____(Please indicate type of #; i.e. mobile/pager)

Secondary Contact # :_____(Please indicate type of #; i.e. mobile/pager)

1. Please list any allergies, medications, contact lenses, or any other pertinent information that may affect the level or type of care that might be required.

_____

_____

2. Family Physician contact information

Physician's name: _____Phone:_____

Physician's address: _____

3. Health Insurance Data

Enrolled Member: _____

Employer: _____ Policy: _____

Group: _____ Contract: _____

This release form is completed and signed of my own free will for the sole purpose of authorizing medical treatment under emergency circumstances.

_____ _____
Printed Name of Participant Date

_____
Signature