



EMERGENCY MEDICAL TREATMENT CONSENT FORM

Name: _____

Phone: (H) _____ (W) _____ (Cell) _____

Address: _____

City: _____ State: _____ Zip: _____

Physician's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Medical Insurance Co.: _____

Company or Agent Phone: _____

Social Security Number: _____

Company Address: _____

City: _____ State: _____ Zip: _____

In the event of an emergency, please notify: _____

Phone: (H) _____ (W) _____ (Cell) _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____

I, the undersigned, do hereby give and grant consent and authorization to the Centaur Stride representative to obtain and have rendered medical aid, treatment, or care to the above named Centaur Stride volunteer/staff in the event of medical necessity.

Signature: _____ Date: _____

(Volunteer/Staff)

Signature: _____ Date: _____

(If under age 18, Parent/Guardian co-sign)