

## Emergency Medical Authorization – Adult

In the event I am incapacitated and unable to provide consent and approval for a situation requiring medical attention and action, the administration of any treatment or care deemed necessary, and my designated representative cannot be reached in a reasonable period of time to provide such consent and approval on my behalf for attention and action for the administration of any treatment and/or care deemed necessary, I hereby give consent to Advanced Care Fitness Inc. to authorize and/or provide such treatment.

The following information is being released by me in the event that the physician, dentist, healthcare professional, or hospital is unable to access my medical history:

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Physical limitations/restrictions: \_\_\_\_\_

\_\_\_\_\_

Other critical information (e.g., blood type, health conditions, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### INSURANCE COVERAGE

Insurance provider: \_\_\_\_\_

Policy number: \_\_\_\_\_

Preferred hospital: \_\_\_\_\_

Representative: \_\_\_\_\_

Signature: \_\_\_\_\_

Name (print): \_\_\_\_\_

Advanced Care Fitness Inc. representative (witness) signature: \_\_\_\_\_

Advanced Care Fitness Inc. representative name (print): \_\_\_\_\_

Date: \_\_\_\_\_ State of: \_\_\_\_\_ County of: \_\_\_\_\_

## Emergency Medical Authorization – Minor/Child

I, the undersigned, am the parents/legal guardian of the minor child(ren) listed below:

\_\_\_\_\_

\_\_\_\_\_

In the event I cannot be contacted within a reasonable period of time to provide consent and approval for a situation requiring medical attention and action, the administration of any treatment or care deemed necessary, for the above mentioned minor child(ren), I hereby consent to Advanced Care Fitness Inc. to authorize and/or provide such treatment.

The following information is being released by me/we on behalf of the minor(s) listed above in the event that the physician, dentist, healthcare professional, or hospital is unable to access the medical history of the above listed minor(s):

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Physical limitations/restrictions: \_\_\_\_\_

\_\_\_\_\_

Other critical information (e.g., blood type, health conditions, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INSURANCE COVERAGE**

Insurance provider: \_\_\_\_\_

Policy number: \_\_\_\_\_

Preferred hospital: \_\_\_\_\_

Representative: \_\_\_\_\_

**CONTACT NAMES AND PHONE NUMBERS**

<b>Contact Name</b>	<b>Contact number</b>
_____	_____
_____	_____
_____	_____

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/guardian name (print): \_\_\_\_\_