Authorization for Emergency Medical Treatment

This form is for the use of New Hampshire International Order of Rainbow for Girls Sessions – Adults Only

I_____ of _____
(Adult) (Street Address)

am affiliated with_____ Assembly, No _____ of the IORG.

I do hereby give my consent and authorize, in the event all reasonable attempts to contact my Emergency contact who is _____at _____ have been taken but are
Name/ relationship telephone
unsuccessful, for the following:

A. The administration of X-ray Examination, Medical Diagnosis or Treatment, and Hospital Care deemed necessary by a Licensed Physician or Dentist.

B. The transfer and admission for care, of myself, to any reasonably accessible Hospital.

The following information is needed by any hospital or practitioner, not having access to my medical history:

Allergies: _____

Medicine Currently Being Taken: _____

Date of Last Tetanus Shot: _____

Any physical impairment: _____

Other Pertinent Facts to which a physician should be alerted:
_____

Family Physician and telephone number: _____

Name, Address & Policy Number of Your Medical Insurance Carrier: _____

I also give my permission for a Nurse or EMT to administer (2) Aspirin, Tylenol, and / or Ibuprofen Tablets to me for headache relief

(2) Aspirin	( ) Yes	( ) No
(2) Tylenol	( )Yes	( ) No
(2) Ibuprofen	( ) Yes	( ) No

_____ _____
Signature of Adult Date

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I give my permission to allow **photos** and my **name** to be used for promotional or informational purposes on the website maintained by the I.O.R.G. in NH (www.nhrainbow.org).

( ) Yes ( ) No

Signature of Adult: _____ Date: _____