



**Permission for Emergency Treatment**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Medical Insurance Company \_\_\_\_\_  
Policy/Group Number \_\_\_\_\_  
Address & Phone of Insurance Company \_\_\_\_\_  
\_\_\_\_\_  
Medications taken Regularly \_\_\_\_\_  
\_\_\_\_\_  
Allergies \_\_\_\_\_  
Health Problems \_\_\_\_\_

**Person/s to be Contacted in Case of Emergency**

\_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Alternate Person/s to be Contacted in Emergency \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

I, being a person authorized by law to give such permission, do hereby give my permission for emergency medical treatment to be given to the person who is the above-named subject of this form. I understand that all reasonable attempts will be made to contact me as soon as possible after the condition necessitating treatment arises, and, that failing to reach me, all reasonable attempts to contact the alternate listed above will be made. I understand that all reasonable precautions will be taken for safety at all times. I further release Tabernacle of Praise, and all persons associated with this organization from any liability associated with any accident, injury, or disease to the person who is subject of the form.

\_\_\_\_\_  
**Signature of parent or legal guardian**

**STATE OF WEST VIRGINIA**  
**COUNTY OF \_\_\_\_\_, TO-WIT:**

I, a qualified Notary Public, in and for the County aforesaid, hereby certify that the person whose signature appears above did, on this date, appear before me, and, after being duly sworn or affirmed, and reading this document in its entirety did affix his or her signature hereto in my presence.

\_\_\_\_\_  
Notary Public  
Date document executed: \_\_\_\_\_  
My Commission Expires: \_\_\_\_\_ **INCLUDE SEAL PLEASE**