EMPLOYEE NAME _____ BIRTHDATE _____

Please print clearly

ASHLAND COUNTY-WEST HOLMES JOINT VOCATIONAL SCHOOL DISTRICT

EMERGENCY MEDICAL AUTHORIZATION PERMIT

Should I become incapacitated and unable to authorize the delivery of emergency medical care, diagnoses, and treatment, including surgical intervention, if necessary, I authorize the individuals listed below to act on my behalf.

This authorization is valid until such time as the authorization is withdrawn.

Authorized Person _____

Telephone Number _____

Authorized Person _____

Telephone Number _____

Doctor Preferred _____ Telephone _____

Doctor's Address _____

Dentist Preferred _____ Telephone _____

Dentist's Address _____

Insurance Company _____ ID Number _____

IMPORTANT MEDICAL INFORMATION

Allergies _____

Current Medications or Treatments _____

_____

Previous Operations or Hospital Confinements _____

_____

Other _____

_____ _____

Signature Date

7/17/2012