

Paws 4 Liberty
Volunteer/Trainee Emergency Medical Treatment Authorization

In the event emergency medical/aid treatment is required due to illness or injury during the process of receiving or performing services or while being on the property of Paws 4 Liberty, I authorize Paws 4 Liberty to:

1. Secure and retain medical treatment and transportation if needed;
2. Release my records upon request to the authorized individual or agency involved in the medical emergency treatment.

Volunteer/Trainee Name: _____ Phone: _____

Street Address: _____

City, State, Zip: _____

Emergency Contacts Names, Phones, and Relationship:

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy # _____

Consent Plan

This authorization includes X-ray, surgery, hospitalization, medication and any treatment procedure deemed necessary by the physician. This provision will only be invoked if the person below is unable to be reached:

Date: _____ Consent Signature: _____

(Volunteer/Trainee, Parent or Guardian)

Print Name: _____ Phone: _____

Street Address: _____

City, State, Zip: _____

Non-Consent Plan

In the event emergency medical/aid treatment is required due to illness or injury during the process of receiving or performing services or while being on the property of Paws 4 Liberty, I wish the following procedures to take place:

Date: _____ Signature: _____

(Volunteer/Trainee, Parent or Guardian)

Print Name: _____ Phone: _____

Street Address: _____

City, State, Zip: _____