MEDICAL EMERGENCY PERMISSION SLIP

PARTICIPANT: **Name** _____

Address _____

City/State _____

Telephone _____

D.O.B. _____

In Case of Emergency Contact:

Name: _____ **Relationship: _____**

Address: _____ **City: _____ Zip: _____**

Phone: _____ **Alt. Phone: _____**

Physician: **Hospital Preference:**

Name: _____ **Name: _____**

Address: _____ **Address: _____**

City: _____ Zip: _____ **City: _____ Zip: _____**

Phone: _____ **Phone: _____**

I _____ (PARTICIPANT OR PARENT/GUARDIAN) give permission to WORKSOURCE staff or a designated representative to transport or arrange transportation to the above physician or hospital, or to the physician or hospital most easily accessible for any medical treatment that may be deemed necessary. If I may not be reached immediately, I authorize medical personnel to provide medical treatment.

_____

PARTICIPANT OR PARENT/GUARDIAN SIGNATURE

_____

DATE