Beaver Local School District
Volunteer Emergency Medical Form

Volunteer Name: ____ DOB: _______________

Address: ____

Home Phone: ___________________________

Cell Phone: ___________________________

Should I become incapacitated/unable to authorize the delivery of emergency medical care, diagnosis, and treatment, including surgical interventions, I authorize the following individuals to act on my behalf.

First Emergency Contact: ____________________________________

Address: ____

Home Phone: ___________________________

Cell Phone: ___________________________

Important Medical Information

Doctor: ____________________________________ Phone: _____________________

Dentist: ____________________________________ Phone: _____________________

Hospital: ____________________________________ Phone: _____________________

Allergies: ____

Current Medications: ____

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Existing Medical Conditions: ____

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Other: ____

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____ ________________

Volunteer Signature Date