Wonderfully Me®

A Girls' Empowerment Program

EMERGENCY MEDICAL TREATMENT AUTHORIZATION *(Please Print Clearly)*

If _____, born on _____, becomes ill or
(Name) *(Date)*

involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give required emergency medical treatment:

Hospital: _____

Address: _____

Phone: _____

Physician: _____M.D.

Phone: _____

Address: _____

I give permission to Wonderfully Me®, Incorporated to take me or my child for treatment.

I understand in an emergency me or my child may be transported to the closest medical facility by ambulance.

I accept responsibility for any expense incurred in the medical treatment of me or my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship: _____

Policy Number: _____Coverage: _____

Medicaid Number: _____ State: _____

Allergies: _____

_____

Physical Conditions: _____

_____

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Signature: _____ Relationship: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

Date: _____

Date Updated: _____