



Return forms to: Mountin' Hopes
P.O. Box 387
Mars Hill, NC 28754
Telephone: (828) 689 2291
E-mail: volcoord@mountinhopes.org

2010 VOLUNTEER'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

NAME _____ PHYSICIAN'S NAME _____

PREFERRED MEDICAL FACILITY _____

HEALTH INSURANCE CO. _____ POLICY # _____

PLEASE LIST TWO EMERGENCY CONTACTS:

NAME: _____ PHONE _____

NAME: _____ PHONE _____

CONSENT PLAN

In the event of an emergency medical aid/treatment is required due to illness or injury while I am participating in the activities of Mountin' Hopes or while on their property, I authorize Mountin' Hopes to secure and retain medical treatment and transportation if needed and to release any applicable volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment. This authorization includes xray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician.

DATE _____ CONSENT SIGNATURE OF VOLUNTEER, PARENT, OR GAURDIAN _____ PLEASE PRINT YOUR NAME _____

NONCONSENT PLAN

I do not give my consent for emergency medical treatment/ aid in the case of illness or injury while I am participating in the activities of Mountin' Hopes or while on their property. In the event emergency treatment/aid is required, I wish the following procedures to take place:

DATE _____ NON-CONSENT SIGNATURE OF VOLUNTEER, PARENT, OR GUARDIAN _____ PLEASE PRINT YOUR NAME _____