

SOUTH FLORIDA SPCA EMERGENCY MEDICAL FORM


Participant's Name:	Birth Date:	Age:
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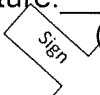
Name of Parent/Guardian (if under the age of 18)		
Home Phone:	Cell Phone:	Work Phone:

In case of emergency, notify:	Relationship:
Contact Number(s):	
Physician's Name:	Preferred Medical Facility:
Health Insurance Company:	Policy #:
Allergies to medications:	

In case of a medical emergency, the undersigned authorizes South Florida SPCA ("SFSPCA") to secure medical, surgical treatment, transportation and/or hospitalization which has been determined necessary, advisable, or lifesaving. This authorization includes, but is not limited to anesthesia, hospitalization, x-ray, surgery and medication.

Although every effort will be made to avoid any accident, no liability can be accepted by any of the organizations concerned, including SFSPCA.

Date: _____ Consent Signature: _____ 
 (Volunteer/Visitor/Employee/Contractor)

Date: _____ Consent Signature: _____ 
 (Parent/Guardian if under 18)

All information provided in the emergency medical release will be kept private and confidential and only used in case of a medical emergency.