R.O.O.C. Inc.

EMERGENCY MEDICAL AUTHORIZATION

In the event of a medical emergency, I request R.O.O.C. Inc. to take _____ to the nearest doctor and/or hospital. I authorize the doctor and/or hospital to provide necessary emergency medical treatment. The medication control form will be supplied to the doctor and / or hospital upon medical emergency.

INSURANCE COMPANY: _____

POLICY NUMBER: _____

MEDICARE NUMBER: _____

MEDICAID NUMBER: _____

SIGNED: _____ DATE: _____
Person Served or Legal Guardian

Valid only one year from date of signature unless waived below.

** I waive the one year limitation and will notify R.O.O.C. Inc. in writing if I wish to withdraw my consent for emergency treatment.

SIGNED: _____ DATE: _____