

Adult Authorization for Medical Treatment (Domestic and Foreign)

1. I, _____, am _____ years of age and a resident of the State of _____.

2. I authorize **Greater Europe Mission** through its agents and/or employees to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon duly licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at said office of said physician or at said hospital, and/or any dentist duly licensed under the provisions of the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said dentist or at said hospital.

3. I authorize **Greater Europe Mission** through its agents and/or employees, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon duly licensed under the provisions in effect in the foreign state/province, country or other state within the United States, where the care is rendered, on the medical staff of a hospital whether such diagnosis or treatment is rendered at office of said physician or at said hospital, and/or any dentist duly licensed under the provisions in effect in the foreign state/province, country or other state within the United States, where the care is rendered, whether such diagnosis or treatment is rendered at the office of the said dentist or at said hospital.

4. I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power of the aforesaid agents and/or employees to give specific consent to any and all diagnosis, treatment, or hospital care which the physicians and/or dentists, in the exercise of their best judgment, may deem advisable and necessary.

5. I understand that the licensing procedure in foreign countries and medical and/or dental care in foreign countries may not be of the same standards and quality as found within the United States.

6. This authorization is given with the understanding that foreign doctors and doctors in other states within the United States are not licensed under the Medical Practice Act and that foreign dentists and dentists in other states within the United States are not licensed under the Dental Practice Act. This authorization shall remain in effect until _____, unless revoked sooner in writing delivered to said agent and/or employee of **Greater Europe Mission**. A photo static copy or carbon copy of this document will have the same force and effect as an original.

7. I am covered under the following health insurance plan(s):

Plan Group No. is _____.

8. My health care coverage as indicated above is valid and will remain in effect while I am traveling in foreign countries and/or other states within the United States. ()Yes ()No

9. I understand that should it become necessary for medical and/or dental care to be provided, the authorizing agent and/or employee of **Greater Europe Mission** assume no responsibility for payment of any and all expenses which may be incurred. I understand that I am fully responsible for payment of all medical and/or dental costs and/or fees which may be incurred. I agree to hold harmless the authorizing agent and/or employee of **Greater Europe Mission** from any liability for payment for said care, should it be authorized.

10. Please give the following specific information or instructions to physician and/or dentist or nurse:

a. I am currently taking the following medications: (Please bring an extra supply of medications.)

b. I am allergic to the following medications: _____

c. I am a diabetic. _____ I am insulin dependent. _____

d. I am a bleeder. _____

e. Please check the following categories for which you have been tested positive:

Hepatitis B _____	HIV _____	Venereal Disease _____
Epilepsy _____	Heart Problems _____	Cancer _____

Comments:

f. I have the following special dietary needs: _____

g. Other: _____

In the event of an emergency, please contact:

Name _____ Address _____

Day/Evening Telephone _____ Relationship _____

Name of physician _____

Address _____ Telephone _____

I acknowledge that I have read the information and understand its contents.

Signature _____ Date _____

Address _____

Day Telephone _____ Evening Telephone _____