

## Refusal of Medical Treatment

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_

Brief Description of Incident: \_\_\_\_\_

By my signature below, I acknowledge that I have reported an incident arising from my participation in activities with \_\_\_\_\_. \_\_\_\_\_ has offered me medical care, to be administered by appropriately-trained members of the crew, and/or to activate Emergency Medical Services (EMS) on my behalf. **I acknowledge that I am refusing medical care.**

I further acknowledge that I understand that it is sometimes impossible to recognize actual or potential medical problems outside of a hospital setting, and that \_\_\_\_\_ has encouraged me to be transported to a hospital by EMS personnel for evaluation by medical professionals. **I acknowledge that I am fully cognizant and competent, and that by refusing transport by EMS, and subsequent professional medical evaluation and treatment, there is a possibility I may suffer serious healthcare/medical complications or even death.** By signing below, I acknowledge that \_\_\_\_\_ has advised me, and that I understand, the potential harm to my health that may result from my refusal of the recommended medical care, and that I release \_\_\_\_\_ and all persons from any liability resulting from my refusal.

*I hereby decline/refuse medical evaluation, care, and transportation.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date