



# RELEASED AT SCENE/AGAINST MEDICAL ADVICE

Date: \_\_\_\_\_ Unit #: \_\_\_\_\_ Incident/Dispatch #: \_\_\_\_\_

## BLS/ALS PERSONNEL

### Section 1 - Released at Scene (RAS)

Neither I nor the attending Emergency Medical Technician(s) (EMTs) and/or Paramedic(s) believe that I (or my child) have an illness or injury requiring Emergency Medical Services (EMS) system transport. I agree that I *do not* need further EMS assessment or treatment and *do not* require EMS system transportation at this time. I understand that if I change my mind, or if my condition changes and I wish further treatment/transportation by the EMS system, I can call 9-1-1 and they will respond.

*Person/Patient Refused to Sign*

Patient Name (print): \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Parent/Guardian Name & Relationship (print): \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Witness Name (print): \_\_\_\_\_ Witness Signature: \_\_\_\_\_

EMT/Paramedic Name (print): \_\_\_\_\_ EMT/Paramedic Signature: \_\_\_\_\_

## ALS PERSONNEL ONLY

### Section 2 - Against Medical Advice (AMA) - Refusal of Evaluation/Treatment/Transportation

I, \_\_\_\_\_ acknowledge that on \_\_\_\_\_  
Patient Name (print) Date

\_\_\_\_\_  
Paramedic Name License # Service Provider Agency

explained my condition to me and advised me of the potential risks and/or complications which could or would arise from refusal of medical care. I have also been advised that other unknown risks and/or complications are possible up to and including the loss of life or limb. Being aware that there are known and unknown potential risks and/or complications, it is still my desire to refuse the advised medical care. I understand that if I change my mind, or if my condition changes and I wish further treatment/transportation by the EMS system, I can call 9-1-1 and they will respond.

All Care Refused       Transportation Refused       *Person/Patient Refused to Sign*

Specific Care Refused: \_\_\_\_\_

I do hereby release EMS personnel from all liability resulting from any adverse medical condition(s) caused by my refusal of the recommended medical care.

Patient Name (print): \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Parent/Guardian Name & Relationship (print): \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Witness Name (print): \_\_\_\_\_ Witness Signature: \_\_\_\_\_

Paramedic Name (print): \_\_\_\_\_ Paramedic Signature: \_\_\_\_\_