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Authorization for Emergency Medical Treatment

☐ Participant ☐ Staff ☐ Volunteer

Personal Info

Name: ____ Date of Birth: ___________________ Age__________

Address: ____

Physician's Name: ________________________ Preferred Medical Facility: __________________________________

Health Insurance Company: ______________________________ Policy #: __________________________________

Allergies ____

Allergies to medications: ____

Current Medications: ____

In the event of an emergency, contact:

Name: ____________________________________ Relation: ______________ Phone #s: ___________________

Name: ____________________________________ Relation: ______________ Phone #s: ___________________

Name: ____________________________________ Relation: ______________ Phone #s: ___________________

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _______________ Signature: ____

Parent/Guardian Signature if under 18 years of age

Non-Consent Plan

I do not give consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _______________ Signature: ____

Parent/Guardian Signature if under 18 years of age

Revised 08/15