AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
Client's Name: _____
Date of Birth: _____ Age: _____
Address:
_____
_____
Physician's Name: _____
Medical Facility: _____
Health Insurance Co.: _____
Policy No.: _____
Allergies to medications?
_____
Current medications:
_____
In the event of an emergency, contact:
Name: _____ Relation: _____
Phone: _____
Name: _____ Relation: _____
Phone: _____
Name: _____ Relation: _____
Phone: _____
In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving treatment, or while being on the property of the practice, and the above cannot be reached, I hereby authorize Shannon Myles, LCSW or farm staff to:
1) Secure and retain medical treatment and transportation if needed.
2) Release participants 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 above is unable to be reached.
Date: _____
Consent Signature : _____
(Client, Parent or Legal Guardian)
MUST BE SIGNED IN THE PRESENCE OF ADIRONDACK EAP STAFF _____ initials