Authorization for Emergency Medical Treatment

___ Servant (18+) ___ Youth (17 or Younger)

Name: _____ DOB: _____ Telephone: _____

Address: _____City: _____State: _____ Zip: _____

Email address: _____

Primary Church's Name: _____

Physician's Name: _____ Telephone: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy # : _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:
Name: _____ Relation: _____ Telephone: _____
Name: _____ Relation: _____ Telephone: _____

Consent Plan

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.

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 unable to reach the emergency contacts.

Date: _____ **Consent Signature**: _____
Parent or Legal Guardian

Non-Consent Plan

I DO NOT give my consent to emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property of the agency.

___ Parent or legal guardian will remain on site at all times during therapy/activities
___ In the event emergency aid/treatment is required, I wish the following procedure to take place:

_____

_____

Date: _____ **Non-Consent Signature:** _____
Parent or Legal Guardian