Authorization for Emergency Medical Treatment

Name: _____DOB: _____ Phone: _____

Address: _____

_____

Physicians Name: _____Medical Facility: _____

Health Insurance Co: _____ Policy # _____
Allergies to Medications: _____

Current Medications: _____

In the event of an emergency contact:

Name: _____Relation: _____Phone: _____

Name: _____Relation: _____Phone: _____

Name: _____Relation: _____Phone: _____

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 Deviations, Inc

I 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:_____ Consent Signature: _____
(Client Parent or Legal Guardian (Signed in the presence of program personnel)

Non-Consent Plan

I do not give my 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: _____ Consent Signature: _____
(Client Parent or Legal Guardian (Signed in the presence of program personnel)