**Emergency Medical Authorization Form**

Purpose — To authorize emergency treatment in case you become ill, injured, or are unable to make a medical decision on your own.

Name: _____ Phone: (  ) _____
Social Security Number: _____ Birth Date: _____

Health Insurance Information:
Insurance Company: _____ Member ID: _____ Health Plan No: _____
Group No: _____cRxBin: _____ RxGroup: _____ RxPCN: _____

CONSENT: I hereby give consent for any of the appropriate medical-care providers or local hospital to be contacted in case of emergency:

Physician: _____ Phone: (  ) _____
Dentist: _____ Phone: (  ) _____
Medical Specialist:_____ Phone: (  ) _____
Preferred Hospital: _____ Phone: (  ) _____

Please list anyone that you would like us to contact in case of an emergency:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

In the event that my house parents and/or the executive director deems that a situation requires medical intervention, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) my transfer to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning your medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

What medications are you currently taking?
Medication Name: _____ Dose: _____ Frequency: _____
Medication Name: _____ Dose: _____ Frequency: _____
Medication Name: _____ Dose: _____ Frequency: _____
Medication Name: _____ Dose: _____ Frequency: _____
Medication Name: _____ Dose: _____ Frequency: _____

Do you have any allergies to medications?
[  ] NO  [  ] YES Explain: _____

Do you have any life- threatening or serious health conditions, physical impairments?
[  ] NO  [  ] YES Explain: _____
_____

Other Necessary Information:
_____
_____

In an emergency and non-emergency situation, my initials serve as consent in each of the following areas:

_____In an emergency, I would like my medical professionals to speak with my house parents and/or the Executive Director about my condition.
_____In an emergency, I give my house parents and/or the Executive Director authorization to approve medications if I am unable to.
_____In a non-emergency, I give my house parents and/or the Executive Director authorization to speak with my medical professionals and for my medical professionals to give my house parents and/or the Executive Director information about my health and/or medications.

_____ _____
Signature of MYA Date