CONNEQTIONS

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Name: _____ Date of Birth: _____

Parent/Guardian/Care Provider: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

In The Event I Cannot Be Reached:

Primary Contact: _____ Phone: _____

Alternate Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____ Phone: _____

Health Insurance Company: _____ Phone: _____

List all pertinent medical information (allergies to food or drugs, medications being taken, special medical conditions): _____

_____

_____

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 organization, I authorize ConnEQtions, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release 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 the contacts listed above are unable to be reached.

_____ _____

CONSENT SIGNATURE DATE

Print Name and Relationship to Rider: _____

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 Suburban Adult Services, Inc. In the event emergency treatment is required, I wish the following procedures to take place: _____

_____

_____ _____

NON-CONSENT SIGNATURE DATE

Print Name and Relationship to Rider: _____