



Ability Training Services Overnight Trip Consent Form

1) In case of a medical emergency, I _____, give Ability Training Services (all staff and providers) permission to seek medical attention for me and/or call 911 as they deem medically necessary. I consent to being released into emergency care if emergency personnel feel it is medically necessary. Furthermore, I consent to receiving medical treatment at and during transportation to a medical facility.

2) I consent to Ability Training Services (all staff and providers) administering first aid as needed. I, _____ understand Ability Training Services (all staff and providers) cannot administer any medications to me. If I feel it is medically necessary to administer any over the counter pain medication, first aid ointments, applying bandages, etc., I will administer such on my own. Ability Training Services (all staff and providers) cannot administer these at any time but may support me with verbal cues in order to administer them to myself properly. I do not hold Ability Training Services liable for any adverse effect of self-administered medications. If I take any medication, whether prescription or over the counter, I will be self-administering it and storing the sealed medication in a safe place within my personal belongings. Ability Training Services cannot administer any medications. This is outlined in the Oregon Administrative Rules.

3) I have disclosed to Ability Training Services any physical and medical barriers I have to participating in activity.

4) I understand that I will be spending ___ night(s) under the supervision and care of Ability Training Services during this overnight outing at _____. I understand that in some hotels or lodgings, due to limited space or facility layout, it may be necessary to stay in the same room with same-sex peers under the supervision of a provider.

5) I agree to follow all Ability training Services policies during this overnight outing. This includes, but is not limited to, not partaking of alcohol, tobacco, or other federally-labeled illegal drugs.

6) I hereby release Ability Training Services of responsibility for any and all damages incurred by me at this overnight outing and accept full responsibility for any and all damages incurred by me at this overnight outing.

Attendee Name: _____ **Attendee Phone Number:** _____

Attendee Address: _____

Attendee Email: _____

Guardian Name (if other than self): _____ **Guardian Phone Number:** _____

Caseworker/ PA Name: _____

List All Allergies (Medication, bees, etc) _____

Primary Doctor _____ **Phone Number** _____

Customer/Attendee Signature _____ **Date** _____

ATS Signature _____ **Date** _____