Authorization for Emergency Medical Treatment

Name: ______________________ DOB: __________ Phone: ______________
Address: ____

Physician Name: ______________________________
Preferred Medical Facility: ______________________________
Insurance Company: ______________________________
Policy Number: ______________________________

Current Medications: ______________________________
Allergies: ______________________________

EMERGENCY CONTACT

Name: ______________________________
Relationship: ______________________________
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 Making Strides of Virginia 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.

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

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury

Date:		Consent Signature:	

Client, Parent or Legal Guardian

Making Strides of Virginia
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