The Bridges Program

Authorization for Emergency Medical Treatment

Name: _____ DOB: _____

Phone: _____

Address: _____

Physician's Name: _____

Medical Facility: _____

Health Insurance Co: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

Date of last Tetanus Shot: _____

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 agency property, I authorize The Bridges Program 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 "lifesaving" 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

Date: _____ Bridges/Witness: _____