



## Authorization for Emergency Medical Treatment

\_\_\_ Client    \_\_\_ Service Provider    \_\_\_ Volunteer

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Current Medications: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone: \_\_\_\_\_

### 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 agency, I authorize Paws for Reflection Ranch 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.

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 unable to reach the emergency contacts.

Date: \_\_\_\_\_ **Consent Signature:** \_\_\_\_\_

Client, Parent or Legal Guardian

### Non-Consent Plan

I DO NOT give my consent to emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property of the agency.

\_\_\_ Parent or legal guardian will remain on site at all times during therapy/activities

\_\_\_ In the event emergency aid/treatment is required, I wish the following procedure to take place:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ **Non-Consent Signature:** \_\_\_\_\_

Client, Parent or Legal Guardian

*Signed in presence of staff*