



Business Office/Mailing Address: 6480 Rockside Woods South, Suite 130 ♦ Independence, OH 44131 ♦ (216) 232-3656
Barn Address: Misty Acres of Bath, LLC ♦ 1683 North Hametown Rd. ♦ Akron, OH 44333

Authorization for Emergency Medical Treatment Form

- Participant
- Staff
- Volunteer
- Other

Name: _____ DOB: _____

Phone: (H) _____ (W) _____ (C) _____

Address: _____

Primary Care Physician's Name: _____

Hospital/E.R. you would want taken to in case of an emergency: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications and your reaction: _____

Current medications: _____

In the event of an emergency, contact: (at least one)

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event of an emergency and 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 or while being on the property of Misty Acres of Bath, LLC, I authorize Hope Meadows Foundation, LLC Staff/Clinicians, and Misty Acres of Bath, LLC Staff 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.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This will only be invoked if the person(s) above is unable to be reached.

Consent Signature: _____ Date: _____
Participant (if participant is an adult)

Consent Signature: _____ Date: _____
Legal Guardian (if participant is a minor)

Consent Signature: _____ Date: _____
Witness

(Non- Consent Plan on back)



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Authorization for Emergency Medical Treatment Form

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 the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Non-Consent Signature: _____ Date: _____
Participant (if participant is an adult)

Non-Consent Signature: _____ Date: _____
Legal Guardian (if participant is a minor)

Non-Consent Signature: _____ Date: _____
Witness