

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical treatment is required due to illness or injury while receiving or providing services or on the property of the agency, I authorize the Access Adventure Driving 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.

Name: _____ Phone _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____ or

Emergency Contact: _____ Phone: _____ or

Emergency Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility _____

Health Insurance _____ Policy # _____

CONSENT PLAN

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Date of Consent: _____ Signature: _____

(VOLUNTEER, PARENT, GUARDIAN)

Print Name: _____ Phone: (H) _____ (C) _____

Address: _____

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury while receiving services or on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date of Consent: _____ Signature: _____

(VOLUNTEER, PARENT, GUARDIAN)

Print Name: _____ Phone: H) _____ (C) _____

Address: _____