AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical treatment is required due to illness or injury while receiving 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:____
Emergency
contact_____________________________Phone_________________________________
or 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:______________Consent Signature:______________________________________
(CLIENT, VOLUNTEER, PARENT, GUARDIAN)
Print Name__________________________________ Phone_______________________
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:

____
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____
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Date______________ Consent Signature:______________________________________
(CLIENT, VOLUNTEER, PARENT, GUARDIAN)
Print Name__________________________________Phone________________________
Address____