AUTHORIZATION for EMERGENCY MEDICAL TREATMENT FORM

Participant

Name:_____DOB:_____Phone:_____

Address:_____City/State/Zip:_____

Physician's Name:_____Preferred Medical Facility:_____

Health Insurance Company:_____ Policy #:_____

Allergies to Medication:_____

Current Medications:_____

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 on the property of the agency, I authorize Kopper Top Life Learning Center 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-rays, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date:_____ Signature:_____

Participant, Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in 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.

_____

_____

Date:_____ Signature:_____

Participant, Parent or Legal Guardian

Signed in the presence of Center staff

Receipt of Treatment Plan

The client or his/her LRP has been informed, in writing, the process for obtaining a copy of his or her treatment plan. You may ask the Director of the program for the treatment plan.

Client Release

Consent for treatment may be withdrawn at any time.