Authorization for Emergency Medical Treatment Form

Name: ___________________________________ DOB: _______________
Phone: (H)___________________(W)___________________(C)_________________________
Address: ____
Physician's Name: ____________________________ Medical Facility: __________________________
Health Insurance Company: ____________________________ Policy #: _________________________
Allergies to medications: ____
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 being on the property of the agency, I authorize PBJ Connections, Inc. 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-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.

Date: ______________ Consent Signature: ____
Participant (if participant is an adult)
or
Date:______________ Consent Signature: ____
Legal Guardian (if participant is a minor)

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:

____
____
____

Date: ______________ Consent Signature: ____
Participant (if participant is an adult)
Date: ______________ Consent Signature: ____
Legal Guardian (if participant is a minor)