



Emergency Medical Authorization

Participant Staff Volunteer

Name: _____ DOB: _____ Phone: _____

Parent/Legal Guardian: _____

Address: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____ Health Insurance Company: _____ Policy #: _____

Dentist's Name: _____ Phone: _____

Describe any medical condition requiring special precautions or treatment; and any medications and dosage:

Emergency Contacts (List 2):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ 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 Equul Access, Inc. to: 1. Secure and retain medical treatment and transportation if needed, and 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 provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Signature: _____

Participant, Volunteer or Staff

Signature: _____

Parent/Legal Guardian if above is under 18

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: _____ Signature: _____

Participant, Volunteer or Staff

Signature: _____

Parent/Legal Guardian if above is under 18