EQUUL Access, Inc.

Emergency Medical Authorization

For: ☐ 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.

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.

Additional Comments:

_____

_____

_____

Date: _____ Signature: _____
Participant, Volunteer or Staff

Signature: _____
Parent/Legal Guardian if above is under 18