Authorization for Emergency Medical Treatment

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Medical Facility: _____

Health Care Insurance: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency contact:
Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical treatment is required due to illness or injury during the process of receiving services or while being on the premises of Special Spirit Inc. facility, I hereby authorize the Special Spirit Inc. staff to secure and retain medical treatment and transportation if needed and to 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 treatment procedure deemed necessary as life saving by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian

Non-Consent Plan

I do not give consent for the emergency medical plan listed above and instead request the following procedures to take place: _____
_____

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian