



Authorization for Emergency Medical Treatment Form

(circle one) Participant Volunteer

Name: _____ DOB _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy#: _____

Allergies: _____

Current Medications including Herbal: _____

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 Open Arms Therapy 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 Plant

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: _____ Consent Signature: _____

Client, Parent or Legal Guardian

Non-Consent Plant

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: _____

Client, Parent or Legal Guardian

Open Arms Therapy signature: _____ Date: _____