



Authorization for Emergency Medical Treatment  
 Staff  Volunteer

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Medical Facility \_\_\_\_\_

Health Insurance Co. \_\_\_\_\_ Policy or Medical # \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Date of last Tetanus Booster \_\_\_\_\_

In case of emergency please contact:

Name \_\_\_\_\_ Relation: \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation: \_\_\_\_\_ Phone \_\_\_\_\_

In the event emergency medical aid or treatment is required due to illness or injury while receiving services or being on the R.H.L.C. property, I authorize R.H.L.C. 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.

If volunteer is under eighteen, please have release signed by parent/legal guardian.

Consent Plan

In case of emergency, I give permission to R.H.L.C. to secure medical treatment and transportation if needed. This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. R.H.L.C. is excused from any and all liability for any decision made in regard to my injury, care and/or hospitalization.

Date \_\_\_\_\_ Consent Signature \_\_\_\_\_

Client, Volunteer, Parent, or Legal Guardian

Non-Consent Plan

I do not give permission to R.H.L.C. to secure medical treatment and transportation if needed. In event emergency treatment is needed, I wish the following procedures to take place.

Date \_\_\_\_\_ Non-Consent Signature \_\_\_\_\_

Client, Volunteer, Parent, or Legal Guardian