JNH-S/3c

JAMESTOWN NEW HORIZONS *Helping children with disabilities sit up tall since 1985*

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RIDER'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

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 Jamestown New Horizons 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.

Name _____ Phone No (____) _____

Address _____

If 18 years or under – Date of Birth ____/____/____

Parent/Legal Guardian Name _____ Phone No (____) _____

Signature of Parent/Legal Guardian _____

Emergency Contact _____ Relationship _____ Phone (____) _____

Emergency Contact _____ Relationship _____ Phone (____) _____

Physician's Name _____ Preferred Medical Facility _____

Health Insurance Co _____ Policy/Group # _____

Allergies to medication _____

Currently taking medications _____

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 parent/legal guardian or contact person is unable to be reached.

Date ____/____/____ Consent Signature _____

Print Name _____

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 ____/____/____ Consent Signature _____

Print Name _____

MFH Missouri Foundation for Health

PLB Productive Living Board – For St. Louis County Citizens with Developmental Disabilities

Partially funded by the Productive Living Board

"Gone Riding"®