

# Authorization for Emergency Medical Treatment Form

**Full Name of participant /camper:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Allergies/Sensitivities:** \_\_\_\_\_

**Physician's name:** \_\_\_\_\_

**Preferred Medical Facility:** \_\_\_\_\_

**Health Insurance Company:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_

**Current Medications (Rx or over the counter):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date of last Tetanus shot:** \_\_\_\_\_

## In the event of an emergency, contact:

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone #** \_\_\_\_\_ **or #** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone #** \_\_\_\_\_ **or #** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone #** \_\_\_\_\_ **or #** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone #** \_\_\_\_\_ **or #** \_\_\_\_\_

**In the event of an emergency: If medical aid/treatment is required due to injury during the process of receiving services, or while being on the property of “the stable”, I authorize Destiny Youth Ranch staff member 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 Plan**

**This authorization includes x-rays, surgery, hospitalization, medication, and 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: \_\_\_\_\_**

## **Non-Consent Plan**

**I do not give my consent for emergency medical treatment/aid on 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:**

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**Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_**