



P.O. Box 92 Kirkersville, Ohio 43033 Phone: 614-395-1395
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Authorization for Emergency Medical Treatment Form

- Participant
- Staff
- Volunteer

Name: _____ DOB: _____
Phone: (H) _____ (W) _____ (C) _____
Address: _____
Physician's Name: _____ Medical Facility: _____
Health Insurance Company: _____ Policy #: _____
Allergies to medications: _____
Current medications: _____

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 PBJ Connections, Inc. 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-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Participant (if participant is an adult)
Date: _____ Consent Signature: _____
Legal Guardian (if participant is a minor)

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: _____
Participant (if participant is an adult)
Date: _____ Consent Signature: _____
Legal Guardian (if participant is a minor)