Hope's Promise
34 South Road
Chester, NJ 07930
973.868.8808

Authorization for Emergency Medical Treatment Form

Name: ____DOB: __________

Phone: (h)__________________(c) __________________(w)____________________

Address: ____

Street Town State and Zip

Caregiver information: Name:____

(Please fill in below if different from above information)

Phone: (h)__________________(c) __________________(w)____________________

Address: ____

Street Town State and Zip

Physician's Name, Town, Phone: ____

Health Insurance Company:____

Policy #: ____________________Group #:______________________________

Allergies to medications or other: _____________________________________

Current medications and dosage: ______________________________________

In the event of an emergency, contact:

Name: _______________________Relation: _______________Phone:______________

Name: _______________________Relation: _______________Phone:______________

CONSENT PLAN

In th event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or whil on the property of the agency, I authorize Hope's Promise personnel 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 treatment.

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 none of the person(s) above can be reached.

Date: _______________Consent Signature: ____________________________________

Client/Volunteer/Staff, Parent (if under 18) or Legal Guardian

To my knowledge, the information I have given on this form is complete and accurate.

Date: _______________Consent Signature: ____________________________________

Client/Volunteer/Staff, Parent (if under 18) or Legal Guardian