

Hope's Promise, LLC

34 South Road
Chester, NJ 07930
973.714.8410

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 the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while 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