Authorization for Emergency Medical Treatment

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, I authorize Centaur Stride staff to:
1. Activate Emergency Medical Services, Provide First Aid or CPR
2. Release client records to the authorized individual or agency involved in the medical Emergency treatment.

Client Name: _____

Consent Signature: _____

Relationship to Client: _____

Emergency Contact-Name: _____

Phone:_____ Alternate phone : _____

Address: _____

Family Physician Name: _____ Phone: _____

Preferred Medical Facility:
_____
Health Insurance Company:
_____Policy#_____

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 person listed below is unable to be reached.
Consent Signature (Client if adult, parent or legal guardian if minor or has legal guardian):

_____Date: _____

Print Name: _____

Phone: _____ Alternate phone: _____

Address: _____

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: _____ Signature of client or parent if minor: _____

PARENTS ARE REQUIRED TO BE ON PREMISES AT ALL TIMES FOR CHILDREN UNDER 12 YEARS OF AGE!