ACCESS ADVENTURE, Inc.

3521 Grizzly Island Road, Suisun, CA 94585
P. O. Box 2852, Fairfield, CA

Authorization for Emergency Medical Treatment

Name: _____DOB: _____

Address: _____

Physician's Name: _____ Physician's Phone: _____

Allergies to Medications: _____Medical Facility: _____

Health Insurance Company: _____Policy Number: _____

Current Medications:

In the event of an emergency, contact:

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone:_____

I
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 Access Adventure 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 deemed "life saving" by the physician. This provision will only be invoked if the person/s above is/are unable to be reached.

Signature _____ Date: _____
Student, Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services from or while being on the property of Access Adventure. In the event emergency medical aid/treatment is required, I wish the following procedures to take place:

Signature: _____ Date: _____
Student, Parent or Legal Guardian

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM