# 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