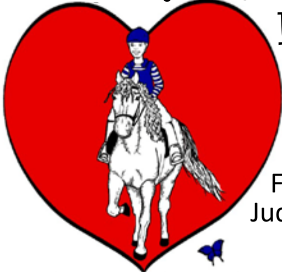
JAF's THERAPY IN MOTION



5730 Lafayette Rd.
Medina, OH 44256
PH: 330-722-2415
FX: 330-722-9684
Judy@JafsTherapy.org

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant ☐ Staff ☐ Volunteer ☐

Name____DOB____________Phone____________________

Address____City___________________________

Physician's Name_________________________Preferred Medical Facility_______________________________

Health Insurance Co.______________________________________Policy #__________________________

Allergies to Medications____

Current Medications____

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 being on the property of **JAF's Therapy in Motion**, I authorize **JAF's Therapy in Motion, Inc.** and **any of its representatives** 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.

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(s) above is unable to be reached.

Date:_____________ Consent Signature:____

Client, Parent, or Legal Guardian, *Signed in presence of center staff*

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 **JAF's Therapy in Motion, Inc**.

In the event emergency treatment/aid is required, I wish the following procedure to take place:

____

____

Date:_____________ Non-Consent Signature:____

Client, Parent, or Legal Guardian, *Signed in presence of center staff*

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

PATH INTERNATIONAL