DUSTY DREAMS
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RIDER'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

In the event emergency medical aid or 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 Dusty Dreams 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.

PARTICIPANT'S NAME: _____ **E-MAIL:** _____

PHONE #1: _____ **PHONE #2:** _____

ADDRESS: _____
Street City State Zip Code

In the event I cannot be reached contact:

PERSON # 1: _____ **PHONE #:** _____

PERSON #2: _____ **PHONE #:** _____

PHYSICIAN'S 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 below is unable to be reached.

DATE: _____/____/_____ **CONSENT SIGNATURE**: _____
MM / DD / YYYY Participant eighteen years of age or older
Or Parent or Guardian (if participant is under the age of eighteen)

PRINT NAME: _____ **PHONE:** _____

ADDRESS: _____
Street City State Zip Code

NON-CONSENT PLAN

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

_____

_____

_____

_____

DATE: _____/____/_____ **NON- CONSENT SIGNATURE**: _____
MM / DD / YYYY Participant eighteen years of age or older
Or Parent or Guardian (if participant is under the age of eighteen)

PRINT NAME: _____ **PHONE:** _____

ADDRESS: _____
Street City State Zip Code

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM. Thank you! ☺