JACKSON COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
Emergency Medical Authorization
Revised 01/07/2013

The purpose of this document is to designate an emergency treatment plan for individuals who become ill or injured while under adult services authority.

Individual's Name: _____ Home Phone: _____

Address: _____

Facility: _____ Grade: _____

Insurance: _____ Medicaid: _____ Medicare: _____

Social Security Number: _____ Date of Birth: _____

Allergies: _____

Medical Problems to inform a physician of: _____

_____

Medications	Dosage	Frequency	Diagnosis/Reason (specific)

Emergency Contact Name	Relationship	Phone Numbers
	Physician	
	Physician	
	Dentist	

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children or adults who become ill or injured while under the supervision of school authorities, when parents or guardians cannot be reached.
In the event reasonable attempts to contact me have been unsuccessful, I hereby give my permission for (1) the administration of any treatment deemed necessary by the above named doctor, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the activation of emergency medical services with transportation by ambulance to any hospital reasonably accessible.
This authorization does not cover major surgery unless the medical opinions of two other physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

<u>ONLY ONE</u> SECTION ON SECOND PAGE MUST BE COMPLETED

PART 1, 2, <u>OR</u> 3 MUST BE COMPLETED

<u>Part 1 – Consent for Emergency Treatment</u>

In the event of an accident, serious injury, or illness requiring more than standard first aide treatment, I, _____ hereby give my consent for administration of standard first aide and necessary emergency treatment to the above named individual.

Signature: _____ Date: _____

<u>Part 2 – Denial of Consent for Emergency Treatment</u>

In the event of an accident, serious injury, or illness requiring more than standard first aide treatment, I, _____ hereby DO NOT give my consent for administration of necessary emergency treatment to the above named individual.

Signature: _____ Date: _____

<u>Part 3 – Consent for First Aide Treatment Only</u>

In the event of an accident, serious injury or illness, I, _____, hereby give my consent for the administration of standard first aide treatment ONLY to the above named individual.

Signature: _____ Date: _____