

TIPP-MONROE COMMUNITY SERVICES, INC. EMERGENCY MEDICAL AUTHORIZATION

PART I GRANT TO CONSENT

PURPOSE: To enable parents to authorize emergency treatment for children who become ill or injured while under TMCS authority, when parents cannot be reached.

NAME: _____ AGE: _____

(Participant's) Last First

Contact Person: _____ Phone: _____

Alternate Contact: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Preferred Doctor: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

In the event reasonable attempts to contact the parents or guardians have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by preferred Dr.(s), or preferred Dentists or in the event designated Dr. or Dentist is not available, by another licensed physician or dentist; and (2) the transfer of the child to preferred hospital or any hospital reasonably accessible.

NOTE: This authorization does not cover major surgery unless the medical options of the two other licensed physicians or dentists, concurring in necessity for such surgery are obtained BEFORE the surgery IS PERFORMED.

Medical History:

Allergies: _____

Medications: _____

Physical Impairments: _____

Date _____ Signature: _____

Parent or Legal Guardian

Date & Initial _____ Date & Initial _____ Date & Initial _____

Part II REFUSAL OF CONSENT

Do not complete if you completed Part I

I do NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish that Tipp-Monroe Community Services to take no action or to _____

Date: _____ Signature: _____

Parent or Legal Guardian