



**AUTHORIZATION FOR EMERGENCY
MEDICAL TREATMENT FORM**

To be completed by the participant, parent or legal guardian

RCTRC, Inc.
Administrative Offices and Facilities:
 RR3Box397
 Milton, WV 25541
 (304) 743-5267
<http://rctrc.org>

GENERAL INFORMATION		
Last Name: _____	First Name: _____	DOB: ____/____/____
Are you a: <input type="checkbox"/> Client <input type="checkbox"/> Volunteer	<input type="checkbox"/> M <input type="checkbox"/> F	Age: _____
Address: _____		
City, State and Zip Code: _____		
E-mail Address: _____	Phone: _____	Alternative #: _____
Physician's Name: _____		
Health Insurance Company: _____	Preferred Medical Facility: _____	
Policy Number: _____		
Parent/Legal Guardian: _____		
Address: (if different from above) _____		Phone: _____
In the event of an emergency, contact:		
Name: _____	Phone: _____	
Name: _____	Phone: _____	
PERSONAL HEALTH HISTORY		
Allergies to Medications: _____		
Medications: (Please include prescription, over-the-counter: name, dose and frequency) _____		
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 RCTRC, Inc., I authorize RCTRC, Inc. to:		
<input type="checkbox"/> Secure and retain treatment and transportation if needed.		
<input type="checkbox"/> Release client records upon request to authorized individual or agency involved in the medical emergency treatment.		
CONSENT PLAN		
<input type="checkbox"/> This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above in unable to be reached.		
Signature: _____		
NON-CONSENT PLAN		
I do not give my consent of emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of RCTRC, Inc.		
<input type="checkbox"/> Parent or legal guardian will remain on site at all times during therapy session.		
<input type="checkbox"/> In the event emergency treatment/aid is required, I wish the following procedures to take place: <input type="checkbox"/> x-rays, <input type="checkbox"/> CPR, <input type="checkbox"/> Surgery, <input type="checkbox"/> specified: _____		
Signature: _____		
MUST BE SIGNED IN THE PRESENCE OF RCTRC, INC. STAFF: SIGNATURE: _____		
Client, Parent or Legal Guardian Signature: _____	Date: _____	