Job Discovery

Partners in Possibility since 1988

EMERGENCY MEDICAL AUTHORIZATION

Date: ___________________________

Employee Name: ____ D.O.B.: ________________

Address: ____ Age: __________________

____ Soc. Sec. #: ___________________

Parent/Guardian:____ Emergency Phone #: __________________

Address: ____
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PURPOSE: Enable employee (legal guardian) to authorize emergency treatment if employee becomes ill or injured at work enroute to the job site or while participating in any agency authorized activity.

1. In the event that, in the judgment of workshop staff, emergency medical treatment is necessary, I hereby give consent for:

A. The administration of any treatment deemed necessary by
   1. _________________________________ (preferred physician), or
   2. _________________________________ (preferred dentist) or in the event of the designated practitioner is not available, by another licensed physician or dentist and:

B. the transfer to ____(preferred hospital) or any hospital reasonable accessible.

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NOTE: The authorization does not cover major surgery unless the opinions of two (2) other licensed physicians or dentists concur in the necessity for such surgery. Such opinions must be obtained prior to the performance of such surgery.

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C. Pertinent Medical Facts (see physical enclosed)
   1. Allergies: ____
   2. Medication:

MEDICATION	DOSAGE	TIMES	REASONS

3. Condition Alert: (Example: blind, arthritis, poor gait-awkward limps, slurred speech/no speech, language comprehension-responds to yes/no - speaks in sentences/phrases, muscle spasms.)

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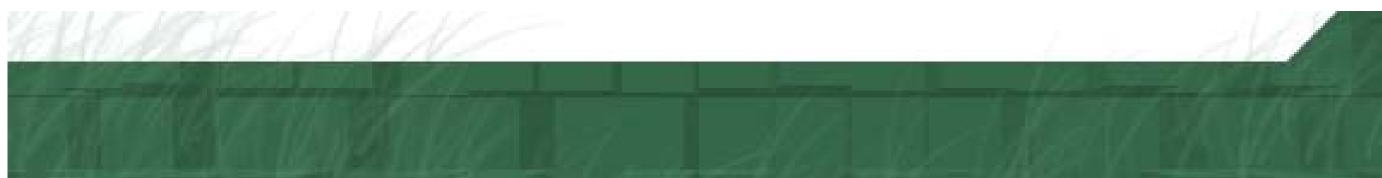
____

3. Date of LAST TETNAUS SHOT:

____

____



Employee Signature Date Parent/Guardian Signature Date

USE THIS SIDE ONLY IF PERTINENT, CHECK HERE IF USING [ ]

II REFFERAL TO TREATMENT

I do <u>not</u> give consent for emergency medical treatment. In the event of illness or injury, I would like the following directions followed:

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______________________________ ______________________________

Employee Signature Date Parent/Guardian Signature Date
(If applicable)

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III DATE TREATMENT RECEIVED (to be completed by emergency Treatment staff

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c.c. Office file
Site file