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Emergency Medical Authorization and Release

Enrollee Information

First Name: _____ Last Name: _____ Phone: _____

Address _____ City: _____ State: _____ Zip: _____

DOB: _____ Sex: _____ SSN: _____ Race: _____ Build: _____

Height: _____ Weight: _____ Hair: _____ Eyes: _____

Emergency Contact:

First Name: _____ Last Name: _____ Phone: _____

Relationship: _____

Legal Guardian:

First Name: _____ Last Name: _____ Phone: _____

Relationship: _____

Address _____ City: _____ State: _____ Zip: _____

Abilities and Challenges:

Physical Challenges: _____

Significant Behavior Characteristics: _____

Relevant Capabilities, Limitations & Preferences: _____

Medical History:

Food Allergies: _____ Medical Allergies: _____

Does Employee have seizures: ☐ Yes ☐ No _____ If Yes, Frequency: _____

Medications	Dosage	Times	Reason

Funding Provided by: Alexandria, Arlington, Fairfax/Falls Church & Prince Williams CSB's, Commonwealth of Virginia, & Host Employers

Physician:

First Name: _____ Last Name: _____ Phone: _____

Address _____ City: _____ State: _____ Zip: _____

Dentist:

First Name: _____ Last Name: _____ Phone: _____

Address _____ City: _____ State: _____ Zip: _____

Hospital:

Preferred Hospital or any hospital reasonably accessible : _____

History of substance abuse: _____

Advance Directive (if any): _____

Purpose:

Enable employee (legal guardian) to authorize emergency treatment if employee becomes ill or injured at work, in route to the job site, or while participating in any agency authorized activity. In the event that, in the judgment of support staff, emergency medical treatment is necessary. I hereby give consent for the administration of any treatment deemed necessary by individual physician or dentist (listed above.) This does not include major surgery unless the opinions of (2) two other licensed physicians or dentists concur is the necessity of such surgery. Such opinions must be obtained prior to the performance or such surgery.

Employee Signature _____ Date: _____

Guardian Signature _____ Date: _____

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