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CLIENT'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving or providing services, or while being on the property of the agency, I authorize Pathways Animal Assisted Therapy, Inc. to:

1. Secure and retain medical treatment and transportation if needed
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Client's Name: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone Numbers: (Work) _____ (Home) _____

In the event I cannot be reached: Contact: _____ Telephone: _____
Contact: _____ Telephone: _____

Physician's Name: _____ Telephone: _____

Preferred Medical Facility: _____ Telephone: _____

Health Insurance Company: _____ Policy No.: _____

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Consent Signature: _____ Date: _____

Client, Parent or Guardian

Print Name: _____ Telephone No.: (W) _____

Telephone No.: (H) _____

Address: _____

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Consent Signature: _____ Date: _____

Client, Parent or Guardian

Print Name: _____ Telephone No.: (W) _____

Telephone No.: (H) _____

Address: _____