AUTHORIZATION TO SEEK TREATMENT

I, the consumer/parent/guardian/conservator of________________________, (Date of birth) ___________, hereby authorize the staff of RFENC respite care program to seek emergency treatment in my absence, in the event of an illness or injury to my child/dependent.

Signed__________________________________

Relationship________________________ Date:________

Emergency Contact_______________________________ Phone________________

2nd Emergency Contact____________________________ Phone ________________

Physician____ Phone ________________

If the child has to go to the hospital which one would you prefer Mercy or SRMC.

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MEDICAL INFORMATION

Allergies:
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____

Medications:
____
____
____

Pre-existing medical conditions:
____
____
____

Signature__________________________ Date_____________________