Emergency Medical Treatment Information

Name:_____ DOB_____ Phone_____

Address:_____

Physician's Name:_____ Medical Facility:_____

Health Insurance Company:_____ Policy #:_____

Allergies_____

Allergies to medications_____

Current Medications:_____

In case of emergency we will notify the person(s) below, apply first aid, and seek medical treatment if necessary.

Emergency contact:

Name:_____

Relationship:_____

Phone numbers including area code: home/business_____

Cell_____

Alternative contact:

Name:_____

Relationship:_____

Phone numbers including area code: home/business_____

Cell_____

YOU MUST SIGN BELOW:

Consent Plan:
In the event emergency medical aid/treatment is required due to illness or injury I authorize Cairns Psychological Services to:

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

Consent Signature_____ Date: _____
Client, parent or legal guardian