Rising Hope Farms

3775 Bethany Church Road
Claremont, NC 28610
(828) 639-0879

Authorization for Emergency Medical Treatment & Health Information Form

☐ Participant ☐ Staff ☐ Volunteer

PATIENT INFORMATION: **PREFERRED MEDICAL FACILITY:** _____

Name: _____ DOB: _____ PHONE: _____

Address: _____

PARENT(S)/GUARDIAN INFORMATION:

Name(s): _____ Phone (C): _____

Address: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

INSURANCE INFORMATION:

Insurance Company: _____ Policy Number: _____

Subscriber's Name: _____ Subscriber's Employer: _____

MEDICAL INFORMATION:

Physicians Name/Address: _____ Physicians Phone: _____

Allergies (if any): _____

Date of Last Tetanus Shot: _____ Tuberculosis Test Date: _____ ☐ POS ☐ NEG

Note: Rising Hope Farms recommends that all volunteers/staff have an up to date tetanus shot. (Please consult your physician if you are not up to date with this shot)

Medications Taking: _____

_____

Medical History (i.e., Diabetes, Heart Diseases, etc.): _____

_____

_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Rising Hope Farms 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.

☐ **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(s) above is unable to be reached. This release is effective until revoked by me and I hereby assume the responsibility for payment of such treatment.

Date: _____ Consent Signature: _____

Client, Parent or Legal Guardian, (*Signed in Presence of RHF Staff)*

☐ **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:

_____

_____

Date: _____ Consent Signature: _____

Client, Parent or Legal Guardian, (*Signed in Presence of RHF Staff)*