Volunteer'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 services, or while being on the property of the agency, I authorize **The Luci Center** 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.

Volunteer's Name: ______________________________ Phone: ____________________________

Address: ____

In the event, I cannot be reached, contact: ____________________ Phone: ______________________
contact: ____________________ Phone: ______________________

Physician's Name: ____

Preferred Medical Facility: ____

Health Insurance Co.: ___________________________________ Policy #: ____________________

Select One Plan

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.

Date: ________________ Consent Signature: ____
Volunteer, Parent or Guardian

Print Name: ____ Phone: ____________________________

Address: ____

Date: ________________ Consent Signature: ____
Volunteer, Parent or Guardian

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: ________________ Non-Consent Signature: ____
Client, Parent or Guardian

Print Name: ____ Phone: ____________________________

Address: ____