Furnace Brook Farm

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant's Name: _____
Date of Birth: ___/___/___ Age: _____ Weight: _____ Height: _____

Primary Contact Name: _____

Relation: _____

Address:_____

Phone: _____ Email: _____

In the event of an emergency

Preferred medical facility: _____

Emergency Contact 1: _____

Relationship: _____ Home Ph: _____

Cell Ph: _____ Preferred phone (circle): Home Cell

Emergency Contact 2: _____

Relationship: _____ Home Ph: _____

Cell Ph: _____ Preferred phone (circle): Home Cell

In the event emergency medical aid/treatment is required due to illness or injury while receiving services, or while on the property of Furnace Brook Farm, I authorize Furnace Brook Farm to:
1. Secure and retain medical treatment and transportation, as needed.
2. Release participant's records upon request to the authorized individual or agency involved in the medical emergency treatment.

This release and authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician or other licensed medical provider. **This consent will only be used if the person(s) listed as emergency contacts cannot be reached.**

Consent Signature (Client, Parent, or Legal Guardian):

_____

Date: _____

253 Sandy Hill Drive ◆Marshfield, MA 02050◆erinfbf@gmail.com◆ (617)650-5524