SPECTRUM Services
PO Box 10806 • Austin, TX 78766
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www.SpectrumSocial.net • Info@SpectrumSocial.net
Phone (512) 524-5482 • Fax (512) 524-1177

Reset Form

Consent For Emergency Treatment

Date Completed: _____

Client's Legal Name: _____ **DOB:** _____

Primary Care Physician: _____ Phone: _____

Insurance Carrier: _____ Policy#: _____

Pertinent Medical / Health History (please check all that apply and provide explanation if needed):

☐ Seizures / Convulsions*
* Must complete a seizure plan

☐ Hemophilia*
* blood type ☐

☐ Asthma*
* please provide inhaler if needed

☐ Food Allergies
(please list below)

☐ High / Low Blood Pressure
(circle which)

☐ Diabetes Type? ☐
Insulin pump? ☐ Yes ☐ No

☐ ADD / ADHD (attention deficit)

☐ Heart Trouble

☐ Kidney Disease

Explain/ Elaborate as Needed: _____

Please list all allergies including food, medications, etc. _____

_____

Chronic Health Conditions: _____

Current Medications _____

Do you have an Epi Pen? ◯ Yes ◯ No If yes, please bring to groups / camps

EMERGENCY CONTACT (to be called if parent / legal guardian cannot be reached)

Name: _____ Relationship to Client: _____

Best Phone: _____ Alternate Phone: _____

Do you give permission for student to be released to this person's care? ◯ Yes ◯ No

I, the undersigned, authorize staff at Spectrum Social and Recreation Services (DBA Spectrum Services), to give the enrolled student first aid and/or CPR when appropriate. I understand that every effort will be made to contact the parent / legal guardian / emergency contact in the event of an emergency requiring medical attention. In the event the parent / legal guardian / emergency contact cannot be reached, I authorize the staff at Spectrum Services to transport (or arrange medical transport – i.e., ambulance) for the student to the nearest medical care facility. I also hereby authorize the performance of medical, surgical, or diagnostic procedures, including the administration of anesthesia, and injections of medications for the student named as deemed necessary or advisable by the attending physician or surgeon in the diagnosis of emergency treatment for the student named in the event that parent / guardian / next of kin cannot be reached for direct authorization of treatment. This consent will be in effect from this date for a period of 2 years unless specifically revoked by me in writing and presented to the records department of Spectrum Services.

_____ _____ _____

Signature of Adult Client / Parent / Legal Guardian **Printed Name** **Date**