

Newport Adolescent ~ Adult Programs, Inc.
Therapeutic Farm Program

637 Union Street • P.O. Box 785 • Newport, VT 05855
802-334-5085 • 800-498-5085

Authorization for Emergency Medical Treatment

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Medical Facility: _____

Health Insurance Co: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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 Newport Adolescent ~ Adult Programs, Inc. to:

1. Secure and retain medical treatment and transportation if needed; and
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.

Date: _____ Consent Signature: _____

Client, Parent or Legal Guardian
Signed in the presence of program personnel

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 the presence of program personnel