ADAPT

CONSENT TO EMERGENCY MEDICAL CARE

I authorize the staff of ADAPT at their discretion and in the event of acute illness, accident, or emergency to seek emergency medical care for me through EMS and/or the nearest medical facility. I understand that neither ADAPT nor its staff will be held responsible for payment of my medical bill that may result from any services that are rendered in my behalf.

Please list any known drug allergies:

1.

2.

3.

4.

5.

List the name, address, and phone number of the person you wish for ADAPT to contact in the event of an emergency.

PRIMARY
NAME
ADDRESS
TELEPHONE NUMBER

ALTERNATE
NAME
ADDRESS
TELEPHONE NUMBER

CLIENT'S SIGNATURE	DATE
STAFF'S SIGNATURE	DATE
PARENT/GUARDIAN SIGNATURE	DATE