THRIVE DAY HABILITATION

Emergency Contact Card

Name:	Today's Date:
Date of Birth:	DDD ID #:
Diagnosis:	
Medical Restrictions/ Special Instructions:	
Allergies/ Past Medical History	

MEDICATIONS

Name	Dose and time(s)	Name	Dose and time(s)

PERSONAL CONTACT INFORMATION

Home Address:	
Email Address:	
Emergency Contact Name:	Emergency Contact Name:
Phone #	Phone #

MEDICAL CONTACT INFORMATION

Primary Physician Name:	
Phone #:	Fax #:
Preferred Hospital:	
Managed Care Organization (MCO):	
Private Insurance ,if applicable:	
Administrative Services Organization (ASO), if applicable:	
Support Coordinator Name:	
Phone #:	Alternate Phone#:

THRIVE DAY HABILITATION
Emergency Consent for Treatment

Name:	
Date of Birth:	**DDD ID #:**

I hereby consent to any and all medical or surgical treatment, including hospital admission, examinations and diagnostic procedures, anesthetics, transfusions and operations, which, **in the event of an emergency** are deemed necessary by competent medical clinicians to save the life or preserve the health of the above named individual. I also approve the release from the case records of any medical history or other medical data, which would be necessary for the physician and/or hospital to administer the treatment.

It is understood that general consent is only applicable specifically and exclusively to emergency situations. In each and every other instance of elective medical and/or surgical treatment recommended by medical professionals, an explicit, individual consent must be requested within a reasonable advance time period. Emergency treatment should be followed by prompt notification of the guardian by the person(s) responsible for the care of the individual.

Applicant Signature: _____

Caregiver/ Guardian Name (please print): _____

Caregiver/ Guardian Signature: _____

Today's Date: _____