EMERGENCY MEDICAL TREATMENT FORM
(TO BE COMPLETED BY CAREGIVER)

Participant Name: _____ Date of Birth: _____

Address :_____ State/ Zip: _____

Caregiver Name: _____

Home Phone: _____ Cell: _____ Work: _____

MEDICAL INFORMATION ***(****Please list all of participant's health care providers and indicate with* ******* *as participant's Primary Physician****)***

	N a m e	**Phone**
Cardiologist	_____	_____
Dentist	_____	_____
Eye	_____	_____
Geriatrician	_____	_____
Internal Medicine	_____	_____
Neurologist	_____	_____
Orthopedist	_____	_____
Podiatrist	_____	_____
Pulmonologist	_____	_____

Preferred Hospital _____ _____

Health Insurance: _____ Group #: _____ Policy #:_____

Medicaid: ☐ Yes ☐ No Medicaid #: _____ Living Will: ☐ Yes ☐ No

List of medications: _____

_____

Dietary Restriction: _____

Drug / Food Allergies: _____

Please list any other information that emergency medical personnel/hospital may need to know (implants, past surgeries, etc.): _____

_____

I understand that first aid will be administered immediately in case of injury, that the need for further medical treatment will be determined by the program supervisor, and, if required, that emergency services will be called for paramedic support. In addition, I do hereby authorize the representative of Successful Living Center, Inc. to have the above named participant transported, as emergency medical personnel deem appropriate for purposes of rendering medical care. I understand that all costs of rendering such care are my responsibility. This form may accompany participant to medical facility to help health care personnel better evaluate my relatives' condition.

_____ _____ _____

Caregiver's Signature Director's Signature Date