Emergency Care, Medication and Transport Authorization Form

Participant Information

Name: _____Date of Birth: _____

Address: _____

Significant Diagnosis: _____

Please list any mental health or emotional support needs relevant to emergency care:

Preferred Hospital/Treatment Center

Facility Name: _____
Address:_____

List of Medications & Dosages

Medication	Name Dosage	Time Given

Emergency Care, Medication and Transport Authorization Form Continued…..

Medication Administration Acknowledgment:

I am requesting assistance in the administration of the prescribed medications listed above to: **Participant Name:** _____ while he/she is attending St. Elizabeth's Adult Day Care. I understand the personnel at St. Elizabeth's will only assist with the medication and are not responsible should the participant refuse to take the medication. The staff will inform me if that occurs. (Medications administered per Physician's Order.)

Allergies

Drug Allergies (if any):	**Food Allergies (if any)**

Dietary Instructions:

_____

_____

_____

Code Status (circle one)

Do Not Resuscitate (DNR) OR **Full Code**

Emergency Care, Medication and Transport Authorization Form Continued…..

Advanced Directives

Does the participant have advanced directives (e.g., living will, durable power of attorney)?

Yes / No

If YES, please attach a copy of the document.

Emergency Transport Permission

In an emergency, St. Elizabeth's has permission to transport this participant:

Yes / No

Emergency Contacts

Primary Emergency Contact:

Name: _____ Phone Number: _____

Secondary Emergency Contact:

Name: _____ Phone Number: _____

Acknowledgment

I understand that any bill incurred under this consent is my responsibility.

Responsible Party Signature: _____

Date: _____

The form must be revised every six months.

01/27/2025