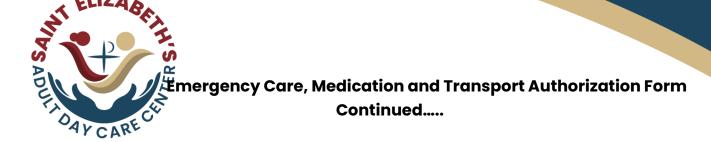


Participant Information				
Name:	Dat	Date of Birth:		
Address:				
Significant Diagnosis:				
Please list any mental healt	th or emotional support needs rele	evant to emergency care:		
		(18)		
Preferred Hospital/Treatm	ent Center			
Facility Name:				
Address:				
List of Medications & Dosa	qes			
Medication	Name Dosage	Time Given		
	41/			



Medication Administration Acknowledgment:

	inistration of the prescribed medications
he/she is attending St. Elizabeth's Adult Elizabeth's will only assist with the med	Day Care. I understand the personnel at Stication and are not responsible should the on. The staff will inform me if that occurs.
Allergies	
Drug Allergies (if any):	Food Allergies (if any)
Dietary Instructions:	
Code Status (circle one)	
Do Not Posuscitato (DNP) OP Full Codo	



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

Primary Emergency Contact:

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

Yes / No

Emergency Contacts

•	Timinary Emergency Community			
1	Name:	Phone Number:		
	Soondary Emorgonoy Contact:			
•	Secondary Emergency Contact:			
I	Name:	Phone Number:		
•				
Acknowle	edgment			
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