



## Emergency Treatment Agreement

Date: \_\_\_\_\_

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I give consent to the Center for Life Transitions to administer acetaminophen up to 650 mg, in the event of headache, pain, or fever. You will be notified in the mode established by you of the time and the amount given.

In the event of an emergency, including illness, accident or injury, I hereby give permission for CFLT to call:

1. Name \_\_\_\_\_ Phone # \_\_\_\_\_

2. Name \_\_\_\_\_ Phone # \_\_\_\_\_

In the case of a serious illness or injury requiring transport to a hospital, I would like to be transported to the following hospital:

\_\_\_\_\_

Signature of Member \_\_\_\_\_

Signature of Guardian \_\_\_\_\_