Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

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Date:_______________ Non-Consent Signature:____ _

(Student (over 18), Parent or Guardian)

Print

____Phone:____________________________

Address:____Na me:_____________________________________ Date of Birth:_________________

Address:____

Name of Parent/Guardian:____

Diagnosis:_________________________________ Date of Onset:_________________

**For Persons with Down Syndrome:

☐ Negative Cervical X-ray for Atlantoaxial Instability. X-ray date__________

☐ Negative for clinical symptoms of Atlantoaxial Instability.

**Seizure participants:

Type_____________ Controlled_____________ Date of last seizure__________

Tetnus Shot: ☐ Yes ☐ No Date_________ Height_________ Weight_______

All types of current medications:____