# EMERGENCY MEDICAL TREATMENT PLAN & AUTHORIZATION

**Participant Name:** ______________________________________________________

I authorize Able-Services, Inc. personnel to seek and/or provide transport for emergency medical care or hospital services for the above listed participant. In addition, I give my permission for treatment and authorize hospital staff, attending physicians, and/or other medical personnel to provide treatment to the above listed participant, as their condition indicates. I understand that this document will accompany the program participant to the hospital or other medical treatment facility as proof of consent for medical or dental procedures that are necessary to preserve life or prevent permanent impairment of health.

**Preferred Hospital/Medical Group:** __________________________________________

**Emergency Contact Information:**

Name: _________________________________________ Phone #: ______________________

Name: _________________________________________ Phone #: ______________________

__________________________________________________________ _______________
Program Participant Signature Date

__________________________________________________________ _______________
Parent/Guardian Signature Date

__________________________________________________________ _______________
Staff Member Signature Date

Able-Services, Inc. is a charitable 501(c)(3) organization as provided by Internal Revenue Service requirements. The official registration and financial information of Able-Services, Inc. may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, 1 (800) 732-0999. Registration does not imply endorsement. This institution is an equal opportunity provider and employer.

3100 North George Street • York, PA 17406 • P (717) 384-6130 • F (717) 855-2533 • Able-Services.org