IDENTIFICATION AND EMERGENCY INFORMATION

NAME OF CLIENT	DATE OF BIRTH	AGE	SEX

CLIENT ADDRESS	TELEPHONE
	( )

CITY	STATE	ZIP

CONSENT FOR EMERGENCY MEDICAL TREATMENT

AS THE CLIENT, AUTHORIZED REPRESENTATIVE, CONSERVATOR, I HEREBY GIVE CONSENT TO **SOUTH BAY ADULT CARE CENTER** TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.), OSTEOPATH (O.D.), OR DENTIST (D.D.S.) FOR ABOVE IDENTIFIED CLIENT.

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB WELL BEING OF THE PERSON NAMED ABOVE.

SIGNATURE OF CLIENT / AUTHORIZED REPRESENTATIVE / CONSERVATOR (CIRCLE APPROPI	DATE

PERSONS TO BE NOTIFIED IN AN EMERGENCY

LIST A MINIMUM OF TWO CONTACTS

NAME	RELATIONSHIP TO CLIENT	1st TELEPHONE	2nd TELEPHONE
1st		( )	( )
2nd		( )	( )
3rd		( )	( )
4th		( )	( )
5th		( )	( )

EMERGENCY HOSPITALIZATION PLAN

HOSPITAL TO BE USED IN EMERGENCY	ADDRESS OF HOSPITAL

MEDICAL PLAN	MEDICAL PLAN IDENTIFICATION NUMBER

CLIENT MEDICATION ALLERGIES	DOES MEMBER HAVE ADVANCE DIRECTIVE? YES	NO

PERSON(S) RESPONSIBLE FOR FINANCIAL AFFAIRS, PAYMENT FOR CARE, LEGAL GUARDIAN, IF ANY

NAME	ADDRESS	TELEPHONE
		( )
		( )
		( )

SIGNATURE

SIGNATURE OF PERSON COMPLETING FORM	RELATIONSHIP TO CLIENT	DATE