Parent, Guardian, or Custodian (P/G/C) Medical Event Contact

Date: _____ Client Name: _____ DOB: _____
Staff Member(s) Present or Witness(s) of the Event/Illness/Injury Being Reported to P/G/C:
_____
Event/Illness/Injury Description: _____
_____
_____

P/G/C Contact Name: _____ Contact Number: _____

P/G/C was informed of the event/illness/injury and has been directed to come and pick the client up from the program at this time with the strong recommendation that the P/G/C take the client to a medical professional such as: a Primary Care Physician, Urgent Care or Emergency Room, for evaluation and treatment as deemed appropriate by the Health Care Professional who provided the care.
(Staff Initial) Yes: _____ No: _____

The P/G/C has further been advised that if they refuse, are unable, or do not respond within a reasonable period of time to pick the client up, the 911 EMS system will be activated and the client will be sent to the appropriate emergency room at their expense should the client's health or well being require immediate medical attention.

(Staff Initial) Yes: _____ No: _____

P/G/C verbalized understanding of all of the above. (Staff Initial) Yes: _____ No: _____

Comments: _____

Date and Time of Contact: _____ Name of Staff who Spoke to the P/G/C: _____

Comments: _____

I, the Parent/Guardian or Custodian of _____ understand that the alternatives program does not offer or provide medical care. I further understand that I have been strongly advised that I should seek medical care for the above named client with a medical professional such as: a Primary Care Physician, Urgent Care or Emergency Room as soon as possible.

P/G/C Printed Name: _____ P/G/C Signature: _____

Alternative Program Staff Printed Name: _____ Signature: _____

Date and Time P/G/C Arrived and This Form was Completed/Signed: _____