#3 Please return this page

Revised 4/2013

Bay Respite Care

CONTACT, ACCIDENT & EMERGENCY INFORMATION

Client & Family Information

Client Name:	DOB:
Mother/LG:	Cell #:
Father/LG:	Cell #:
Address:	Home Phone:
City: State: Zip:	Mom Work #:
Email Address:	Dad Work #:
Emergency Contact (EC):	EC Phone #:

Medical Information

Doctor:	Dr's #:
Nearest Hospital:	Does client have seizures?
Client's Medical Conditions:	Controlled by medications?

Respite Care Provider Instructions in case of a Disaster

What should the RCP do?	
Whom should the RCP contact?	

Permission For Emergency Treatment

Legal Guardian/Parent Signature _____

Date _____

(I)(We), the undersigned, parent/legal guardian of _____ authorize Bay Respite Care at 201 Georgia St., Vallejo, CA 94590 (707/644-4491) as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provision of the Medicine Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable; and neither said agent or any organization assumes any financial responsibility for exercising this action.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and remains effective until revoked in writing and delivered to said agent(s).