Emergency Information & Authorization for Emergency Medical Treatment

4173 MacArthur Boulevard
Oakland, CA 94619
510-336-2900
FAX 510-336-2903

Place a copy on refrigerator or in plain sight. Please send white copy to Manos Home Care.

Copies: White–Office Yellow–Employee Pink–Authorized Representative/Client

Client Name		Birth Date	
Phone		Health Plan	
Address		Health Plan #	
City		Hospital Name	
Zip Code		Hospital Phone	

Authorized Representative Information

Name	Home Phone	Work Phone	Cell Phone	Relationship

Besides Authorized Representative, Others Residing in the Client's Home (siblings, other relatives, friends, etc.)

Name	Birth Date	Name	Birth Date

Developmental and/or Intellectual Disability(ies)

Diagnosis(es) — Please check the appropriate box(es):

- ❑ Autism/ASD
- ❑ ADHD
- ❑ Behavior Disorder
- ❑ Cerebral Palsy
- ❑ Brain Injury
- ❑ Down Syndrome
- ❑ Spina Bifida
- ❑ Seizures (Petit Mal)
- ❑ Seizures (Grand Mal)
- ❑ Vision Impairment
- ❑ Hearing Impairment
- ❑ Intellectual Disability
- ❑ Other (list below): _____

Illness(es), Injury(ies), and/or Allergy(ies)

List Here	

Medication(s)

List Here	

Contacts

	Name	Home Phone	Work Phone	City
Friend				
Neighbor				
Nearest Relative				
Doctor				

This sheet is provided by Manos Home Care for the convenience of the authorized representative or client we serve. It is the responsibility of the authorized representative or client to keep the information current. Manos Home Care does not keep medical records of clients, and is not responsible for any monitoring or dispensing of medications that may be listed on this form. Manos Home Care direct support providers are not allowed to take prescription medications out of their bottles, but can assist in administering medications when these medications are set up in a container where each dosage is predetermined, and when there are written instructions for when the medications are to be taken by the client. For further questions, please call 510-336-2900.

Authorization for Emergency Medical Treatment:

By signing this agreement, the authorized representative/client affirms that they are the person authorized to enter into this agreement, and authorizes the direct support provider on duty to seek and obtain emergency medical treatment for the clients listed above if circumstances appear to warrant such treatment. The authorized representative/client agrees to reimburse the person or persons who obtain such emergency medical treatment for any expense reasonably incurred. The authorized representative/client agrees to indemnify the person or persons who obtain such emergency medical treatment from any and all claims for payment by medical service providers arising from the authorization of reasonable medical expenses.

Printed First & Last Name of Authorized Representative/Client _____ Signature _____ Date ___/___/___