LCBDD/Deepwood **Policy H-2**
EMERGENCY MEDICAL TREATMENT AUTHORIZATION (EMTA) AND AUTHORIZATION TO ADMINISTER MEDICATION

LAKE COUNTY BOARD OF DD/DEEPWOOD
EMERGENCY MEDICAL AUTHORIZATION

Individual Name: _____Program(s) _____ DOB: _____

Address: _____ Phone: _____

City/Zip_____

Guardian/Provider Name: _____Daytime Phone: _____
Address: _____ Phone (other): _____
City/Zip: _____

Co/Guardian _____Daytime Phone: _____
Address: _____ Phone (other): _____
City/Zip: _____

PART I OR II MUST BE COMPLETED

PART I: To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor:_____ Phone:_____
Dentist:_____ Phone:_____
Medical Specialist:_____ Phone:_____
Local Hospital: _____ ER Phone:_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of this individual to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the individual's medical history including allergies, medications being taken, modified diets, diet supplements, fluoride supplements and any physical impairments to which a physician should be alerted:

_____

_____

Date:_____ Signature of Individual/Guardian:_____

PART II: Refusal to Consent

I do NOT give my consent for emergency medical treatment of this individual. In the event of illness or injury requiring emergency treatment. I wish the LCBDD authorities to take the following action:

_____

_____

Date:_____ Signature of Individual/Guardian:_____

EMERGENCY MEDICAL AUTHORIZATION
SECTION 3313.712, OHIO REVISED CODE

(A) Annually the Lake County 169 Board shall provide to individuals (guardian) enrolled in any program under the Board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section.

When the form is returned to the program area with Part I or Part II completed, the primary program area shall keep the form on file, distributing copies to other areas in which the individual participates. Upon request of the individual (guardian), the program director may permit changes in previously filed form to be made, or to file a new form.

If the individual (guardian) does not wish to give such written permission, (s)he shall indicate in the proper place on the form the procedure (s)he wishes Board authorities to follow in the event of a medical emergency involving the individual.

Even if the individual (guardian) gives written consent for emergency medical treatment, when an individual becomes ill or is injured and requires emergency medical treatment while engaged in Board activities, Board authorities shall make reasonable attempts to contact the guardian or emergency contact before the treatment is given. The Board authority shall present the individual's emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any board official or Board employee who, in good faith, attempts to comply with this section.

AUTHORIZATION TO ADMINISTER MEDICATIONS (DO NOT COMPLETE IF RECREATION REFERRAL – if medication administration is required, please contact the Recreation Department directly prior to registering for any activity per the LCBDD Procedure "Recreation and Special Olympics Medication Protocol")

Medications are administered to consumers by a licensed nurse or ODDD certified DD personnel while attending LCBDD/Deepwood programs (excluding self administered medications). A physician order is required for all prescription and non-prescription drugs, food supplements and modified diets. It is the responsibility of the consumer/guardian/residential provider to provide a complete list of medications, food supplements and modified diet orders as well as the medication and above mentioned specialized food supplements needed by the consumer. Notification to the nursing department of any changes in medication or diet is the sole responsibility of the consumer/guardian/residential provider. I have been informed of the risks and benefits of these medications & diets by the prescribing health care professional and I consent to their administration.

_____ Date:_____
Signature of Individual/Guardian

(B) The emergency medical authorization form provided for in division (A) of this section is attached as C, 1.