BEHAVIOR SUPPORT
North Dakota Autism Center

Consent of Emergency Medical Treatment

I/We hereby give permission to the North Dakota Autism Center, Inc. (NDAC) staff to call my/our physician for medical advice should any serious situation arise. I/We also give permission to the NDAC to discuss with my/our doctor any situation or concerns he/she may have regarding the well-being of my/our child. I/We hereby release the NDAC and/or agent from any liability in any situation regarding the health of my/our child, including but not limited to known or unknown allergies to prescription or over-the-counter medications.

I/We hereby give my/our permission for my/our child to be given emergency treatment (First Aid and CPR) by a certified staff member at the NDAC, if needed.

I/We also give my/our permission for my/our child to be transported by ambulance and treated by EMT staff, as needed in the case of an emergency.

In the event that I/we cannot be reached, I/We further give consent to the medical, surgical, and hospital staff to provide any treatment or procedures, which are deemed necessary or advisable by the physician to safeguard my/our child's health.

☐ Check the box if you agree to the above statement

In the event of an emergency and/or if emergency transportation is needed, I/we agree to pay all costs involved.

Child's Name _____

_____ _____

(Mother/Guardian) (Date)

_____ _____

(Father/Guardian) (Date)

Note- A copy of insurance card is preferable for any emergency events that could lead to hospital visit.

NORTH DAKOTA AUTISM CENTER