

Caregiver Consent Form for Emergency Treatment

Today a head of household often has to delegate the care of a loved one to a caregiver. Most often this involves ensuring care for a grandparent who cannot act on his or her own.

The caregiver could be one of many types of people:

- A teen-aged child care provider for an evening.
- An adult friend or relative for an extended period of time.
- A professional caregiver, such as a nurse or home health aide.
- A housekeeper.

Whatever the situation, it's important to plan for the unexpected. If a medical emergency arises while the head of the household is away, caregivers must be able to make decisions for those in their care. Medical care personnel responding to the emergency must be assured that the caregiver has the authority to act for you.

Caregiver Consent Form

A Caregiver Consent Form, prepared in advance, assures that the caregiver will be able to make medical decisions guided by health care professionals in your absence. You can create these forms without the need for a lawyer. Place prepared consent form copies next to emergency phone numbers. *Review the Caregiver Consent form and emergency phone numbers frequently to keep them current.*

Information to include:

- Stated permission to have the caregiver arrange for emergency medical care.
- Name of person receiving the care.
- Name of the caregiver.
- Name of head(s) of household and address.
- Insurance carrier, with policy and group number.
- Expiration date of consent.

Multiple or Customized Forms

The form on the next page can be photocopied as often as needed. Or, you may want to devise your own form using it as a model.

It is not meant to take the place of sound legal advice. You may want to consult with your attorney to be certain it is appropriate for your family's particular needs.

Be sure to instruct your caregivers:

- On the need for and use of the consent forms.
- That the consent forms are in or by emergency phone numbers.
- To give the Caregiver Consent Form to the Emergency Medical Service or to take it to the emergency room so all necessary information for prompt and appropriate care will be available in your absence.
- To become familiar with the name and group number of your insurance carrier, a critical concern to hospitals or other emergency centers.

Keep a photocopy of your Insurance ID Card with the form.

Consent for Medical and/or Emergency Treatment

I, _____, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, and blood transfusions, by medical doctors, hospitals or their authorized designees, as may in their professional judgement be necessary to provide for the medical, surgical or emergency care of my

(Relationship – “Grandmother” or “Grandfather”)

(hereafter “dependent”) – Full Name

I further give my consent to _____,
(hereafter “caregiver”) – Full Name

who will be caring for my dependent for the period _____ through _____, to arrange for routine or emergency medical and/or dental care and treatment necessary to preserve the health of my dependent. In the event that my dependent is injured or ill while under the care of the caregiver, I hereby give permission to the caregiver to provide first aid for said dependent and to take the appropriate measures, including contacting the Emergency Medical Service (EMS) system and arranging for transportation to the nearest emergency medical facility.

In making medical decisions on my behalf for the benefit of my dependent, I direct that the caregiver attempt to contact me. However, if medical care becomes essential, I give permission to the caregiver to make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by the caregiver on my behalf for the benefit of my dependent, I authorize the caregiver to request, obtain, review and inspect any and all information bearing upon my dependent’s health and relevant to any such decisions to be made respecting such treatment.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of my dependent and that I am responsible for all reasonable charges in connection with the care and treatment rendered to my dependent during this period.

Signature of Legal Guardian

Primary Care Physician’s Name

Signature of Witness

Primary Care Physician’s Address

Witness’s Name

Primary Care Physician’s Address 2

Witness’s Address

Primary Care Physician’s Phone

Witness’s Address 2

Witness’s Phone

Current Medications

Health Insurance Carrier

Health Insurance Policy # and Group #

Allergies

Date of Last Tetanus Booster

Allergies (*cont’d*)

Medications Dependent is taking