ALL GENERATIONS
ADULT DAY CENTER

Medical Emergency Plan

I give my permission for All Generations Adult Day Centers' staff to seek emergency medical and/or hospital care if in case of a medical emergency. I understand that I, the participant, will be responsible for the cost of such medical services and/or other expenses incurred.

I authorize All Generations Adult Day Center to:

- Arrange for Emergency Transportation and/or transport in company or employee vehicle
- Contact family/caregiver of participant
- Contact participant's Primary Physician:

  Name……._____

  Address…. _____

  Phone…… _____
- If Primary Physician is unavailable, I authorize treatment by E.R and/or Urgent Care Physician.

I understand that All Generations Adult Day Center will make reasonable effort to contact my physician and/or family member/ caregiver.

Signature of Participant _____

Date_____

Signature of Responsible Party _____

Date_____

Relationship to Participant_____

Date_____