Authorization for Medical Services

In case of an emergency, illness, accident or injury, I hereby authorize PORT Group Homes to take, at its discretion, any action necessary for the health and welfare of my child, _____ while in residence at PORT.

Medical Insurance Company is:_____

Subscriber: _____

I also authorize any and all medical bills, including prescriptions, to be billed to me the undersigned**.**

My insurance company is:_____

My insurance group # is: _____

My Medical ID # or SSN # is: _____

My child's SSN # is: _____

My child's Medical Assistance # is:_____

Dental insurance company is: _____

Subscriber: _____

My dental insurance company's address is: _____

My Dental ID # or SSN # is: _____

Current medications my child is taking: _____

Is child allergic to any medications? [ ] Yes [ ] No

If yes, explain: _____

Family or child's physician: _____

Address and phone number: _____

Last time child was seen by a physician:_____

My child is now being treated for: _____

My child has a medical history of the following: _____

_____

My place of employment is: _____

Signed: _____ Relationship: _____ Date: _____

**Please include a copy of your child's social security card and each insurance card. If you do not have the card, please contact your client's Primary Counselor or the local Social Security office for assistance in receiving a duplicate.

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