EMERGENCY ACTION TREATMENT AGREED CONSENT FORM

Name	
Date of birth	
Condition	Angina Diabetes 1 Epilepsy Asthma Allergic response Other
Medication Dosage Frequency **Location** (eg handbag)	
Symptoms of emergency situation	
Treatment	
Assist in administration of medication	*What is required – eg epi pen/sublingual*
Emergency contact (1) Name Mobile	
Emergency contact (2) Name Mobile	*(if appropriate)*
Permission to call 999 for medical assistance	*(yes/no)*
How quickly should your symptoms normally improve?	
Anything else I should know?	

(Revisit form every 3 months and/or if update is advised at pre-treatment consultation)

Signature: Date:

Signature: Date:

Signature: Date: