Teen Leadership Troy

Emergency Medical Consent Form

Name ______________________________ **Home phone** ________________________

Address_____________________________ **Birth date** ___________________________

City/State/Zip _______________________

Mother's Name: Legal Custodian Y or N	Home Phone: Cell Phone:	Place of Employment: Work Phone:
Father's Name: Legal Custodian Y or N	Home Phone: Cell Phone:	Place of Employment: Work Phone:
Other person to contact if parents are not available:		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Part I: To Grant Consent for Medical Treatment

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for students who become ill or injured while participating in the Teen Leadership Troy week when parents or guardians cannot be reached, I hereby give consent for the following medical care providers and local hospital to be called:

Physician ____________________________________ Phone: _______________________

Dentist ______________________________________ Phone: _______________________

Medical Specialist ______________________________ Phone: _______________________

In the event reasonable attempts to contact me have not been successful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the student to any hospital reasonably accessible.

Date ________ __ **Signature of Parent/Legal Guardian** ____________________________________

Part II: Refusal To Consent For Medical Treatment

I do NOT give consent for emergency medial treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the leaders of TLT to take the following action:

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Date __________ Signature of Parent/Legal Guardian ______________________________________