

EMERGENCY INFORMATION & TREATMENT CONSENT FORM

I. Participant Name _____ Grade _____

Address _____

City _____ State _____ Zip _____

Phone _____ E-Mail _____

II. Family Information (if participant is a minor)

Parent/guardian (First/Last/MI) _____ Home Phone _____ Cell Phone _____

Address _____ Employer _____

Work Phone _____ Work Address _____

Parent/guardian (First/Last/MI) _____ Home Phone _____ Cell Phone _____

Address _____ Employer _____

Work Phone _____ Work Address _____

Parent E-mail _____

III. Health Information

Participant's Physician _____ Phone _____

Address _____ Insurance Co. _____

Employer group # _____ Policy Holder Name _____ Member # _____

Please advise us of any learning disabilities, emotional or physical conditions to assist us in providing the best experience for the participant.

Medications that the participant may need:

Medication allergies - Describe reaction and management of the reaction:

Food and Other allergies - include insect stings, hay fever, asthma, animal dander, etc. – Describe reaction and management of reaction:

IF PARTICIPANT IS A MINOR, PARENT OR GUARDIAN MUST READ AND SIGN BELOW:

Informed Consent for Emergency Treatment: In the case of an emergency and if I can not be reached, I authorize the staff of UCLA to obtain whatever medical treatment he/she deems necessary for the welfare of my child. I further understand and agree that I will be financially responsible for all charges and fees incurred in the rendering of said emergency treatment regardless of whether or not my medical insurance would cover such charges and fees.

IMPORTANT PLEASE READ AND SIGN BELOW

I am the parent or legal guardian of the minor _____, and I am signing on behalf of said minor.

Name of minor

Print Name of Parent/guardian _____

Signature of Parent/guardian _____ Date _____

This consent will remain in force for duration of the program.