MEDICAL CONSENT FORM and
LIABILITY RELEASE AGREEMENT

NAME OF PARTICIPANT: ____ **AGE:**__________

NAME OF PARENT/GUARDIAN (printed): ____

HOME ADDRESS:____

TELEPHONE NO:_________________________**CELL PHONE**:______________________________

ALTERNATIVE PERSONS TO CONTACT:

____

NAME RELATIONSHIP PHONE NUMBERS (Including Mobile Phone Number)

PRIMARY CARE PHYSICIAN:

____

NAME PHONE NUMBER

____

HEALTH INSURANCE CARRIER INSURANCE ID NO. NAME OF INSURED

____

PHONE NO. FOR VERIFICATION CLAIMS MAILING ADDRESS

Existing Medical Problem Medication Taken Dosage Taken Dosage Frequency
(Example: Asthma) (Example: Combivent) (Example: 2 puffs) (Example: "Twice Daily")

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____

Medical Consent Authorization:

In the event of an injury, accident, illness or other emergency, and if the above stated physician cannot be reached, I authorize ____ myself _____ my child to be treated by certified emergency personnel such as emergency medical technicians, emergency room physicians and other emergency room personnel such as nurses and laboratory technicians. I agree to accept financial responsibility for the costs related to this medical treatment.

Parent or Guardian's Signature: ____

Date: ____________________

Note: This form is designed to present general consent for emergency medical treatment and may not include all the requirements of your state. You should consult with a legal professional to ensure that all of your medical, legal and financial rights are protected.