



CONSENT FOR EMERGENCY MEDICAL TREATMENT

Name of Participant: _____ Organization: _____
(Please Print) (If applicable)

Gender: _____ Height: _____ Weight: _____ Age: _____
Address: _____ Phone: _____

In case of emergency please notify (name): _____
Phone: _____ Relationship to Participant: _____
Cell Phone: _____ Other Phone: _____

Physician name: _____ Phone: _____

Health insurance carrier/provider: _____ Phone: _____

I hereby acknowledge that if the Participant becomes injured, suffers from illness, or otherwise requires medial treatment while engaging in Program activities, the Activity Providers will proceed at their discretion by taking any measures that they deem are appropriate to the type and extent of the injury or illness. Except in the case of emergency first-aid procedures, the Activity Providers shall attempt to contact the emergency-notification person designated above, prior to taking any action relating to medical treatment. I acknowledge that the Activity Providers are under no obligation to contact the emergency-notification designee prior to providing first-aid treatment.

I hereby acknowledge that I have fully informed the Participant's physician of the strenuous physical activities involved by participation in the Program, and the physician has stated that the Program poses no special risks to the Participant's health, and does not oppose participation because of illness, injury, surgery, or other medical conditions.

Print Participant Name

Signature of Participant

Date

Print Parent or Guardian Name

Signature of Parent or Guardian

Date