

EMERGENCY INFORMATION & TREATMENT CONSENT FORM

I. Participant Information

Name _____ Age _____
Address _____
City _____ State _____ Zip _____
Phone _____ Email _____

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:

IMPORTANT: PLEASE READ AND SIGN BELOW. If the participant is a minor, a 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 they deem 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. This consent will remain in force for duration of the program.

Participant Name (print): _____

Signature: _____ Date: _____

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

Parent/Guardian (print): _____

Signature of Parent/guardian _____ Date _____