Department of Youth & Community Development

Consent for Emergency Medical Treatment

FOR ADULT PARTICIPANTS (AGE 18 AND OVER):

I am enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment to be obtained on my behalf. I further authorize the emergency contact listed below to be contacted.

☐ Yes ☐ No

_____

Full Name of Participant

_____

Participant's Signature

_____

Date

In the event of a medical emergency, I designate the following person as an emergency contact:

_____

Name of Emergency Contact

_____

Phone Number

_____

Relationship to Me

FOR PARTICIPANTS WHO ARE MINORS (UNDER AGE 18):

My child is enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment for my child to be obtained, with the understanding that I will be notified as soon as possible. I understand that every effort will be made to contact me, or, if I am unavailable, the emergency contact listed below, before and after medical care is provided.

☐ Yes ☐ No

_____

Full Name of Participant

_____

Parent's/Guardian's Signature

_____

Parent's/Guardian's Phone Number

_____

Date

In the event of a medical emergency, where I cannot be reached, I designate the following person as an emergency contact:

_____

Name of Emergency Contact

_____

Phone Number

_____

Relationship to Me

_____

Relationship to Child (if applicable)