



Consent for Emergency Medical Treatment

Participant Name	Date of Birth
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Home Address	Phone Number
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In the case that I cannot be contacted during a medical emergency, I give consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, blood transfusions, diagnostic tests, etc.), for the above named person, which may be required during my absence. If circumstances permit, I would like to have our doctor consultant in connection with such treatment.

Please attempt to contact me at the following telephone number: _____

This consent serves as permission for treatment by the nearest hospital.

Parent/Guardian (circle one)	Date
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Witness	Date
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