# 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 under 18, he/she is a minor, and 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_____