INDIAN CENTER INC YOUTH PROGRAM

EMERGENCY MEDICAL TREATMENT CONSENT

I, _____, understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child, _____. However, if I cannot be reached I hereby authorize the staff of the Indian Center, Inc. to secure the necessary medical treatment for my child, including anesthesia.

_____ Date:_____
(Parent/Guardian's Signature)

Child's Physician Information (**REQUIRED)**

Physician's Name: _____
Address: _____ Business Phone #: _____

Child's Health Information

1. Is your child allergic to any medications? Yes ___ No ___
   If yes, please list all applicable medication:\
   _____
   _____

2. Does your child have other allergies? Yes ___ No ___
   If yes, please list all known allergens:
   _____
   _____

3. Does your child have any physical restrictions or special needs? Yes ___ No ___
   If yes, please explain:
   _____
   _____

4. Is your child taking any medications on a regular basis? Yes ___ No ___
   **Indian Center, Inc. staff has no authorization to administer medication. Parents will be required to visit the site to administer medication to child(ren) as needed. Additionally, children are not to administer their medication or bring medication to the site, for the safety of all the children.*

I have read and understand the above Emergency Medical Treatment Consent Form:

_____ Date: _____
(Parent/Guardian's Signature)

Revised 12/28/2012