

**Teen Leadership Troy**  
**Emergency Medical Consent Form**

Name \_\_\_\_\_ Home phone \_\_\_\_\_  
 Address \_\_\_\_\_ Birth date \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_

|                                                       |               |                      |
|-------------------------------------------------------|---------------|----------------------|
| Mother's Name:                                        | Home Phone:   | Place of Employment: |
| Legal Custodian Y or N                                | Cell Phone:   | Work Phone:          |
| Father's Name:                                        | Home Phone:   | Place of Employment: |
| Legal Custodian Y or N                                | Cell Phone:   | Work Phone:          |
| Other person to contact if parents are not available: |               |                      |
| Name:                                                 | Relationship: | Phone:               |
| Name:                                                 | Relationship: | Phone:               |

**Part I: To Grant Consent for Medical Treatment**

**Purpose:** To enable parents and guardians to authorize the provision of emergency treatment for students who become ill or injured while participating in the Teen Leadership Troy week when parents or guardians cannot be reached, I hereby give consent for the following medical care providers and local hospital to be called:

Physician \_\_\_\_\_ Phone: \_\_\_\_\_  
 Dentist \_\_\_\_\_ Phone: \_\_\_\_\_  
 Medical Specialist \_\_\_\_\_ Phone: \_\_\_\_\_

In the event reasonable attempts to contact me have not been successful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the student to any hospital reasonably accessible.

Date \_\_\_\_\_ Signature of Parent/Legal Guardian \_\_\_\_\_

**Part II: Refusal To Consent For Medical Treatment**

I do NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the leaders of TLT to take the following action:

\_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Legal Guardian \_\_\_\_\_