EMERGENCY TREATMENT CONSENT FORM

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I affirm I am the parent and/or legal guardian of _____. As the
NAME OF MINOR

parent/guardian, I hereby authorize _____, and/or its agents,
(DIVE CENTER/RESORT/INSTRUCTOR)

employees or assigns, to seek medical treatment for _____, as a result
(MINOR)

of an accident or illness while under the supervision of _____.
(DIVE CENTER/RESORT/INSTRUCTOR)

I affirm I have read the **Certificate of Understanding and Express Assumption of Risk** form, signed it of my own free will, and understand the legal consequences of signing the document.

I authorize the treatment of _____, by a qualified and
(MINOR)

licensed physician in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed.

I have fully informed myself of the contents of this **Emergency Treatment Consent Form** by reading it before I signed it.

_____ _____
PARENT/GUARDIAN (please print) DATE

_____ _____
SIGNATURE OF PARENT/GUARDIAN HOME PHONE

_____ _____
ADDRESS WORK PHONE

_____

Specific medical allergies, medicine being taken or other conditions physician should be aware of (if none, please write NONE):

_____

_____

Medical Insurance Company: _____

Policy Number: _____

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