OCCIDENTAL COLLEGE EMERGENCY MEDICAL CARE AND RELEASE AUTHORIZATION

Program Name: _____ *Program Dates:* _____

This document is being signed in conjunction with the Assumption of Risk, Release of Liability, and Indemnity Agreement, and grants temporary authority to an Occidental College Program employee or volunteer to provide and arrange for medical care for my child in the event of an emergency, where my child is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them.

Child's Name: _____ Date of Birth: _____ Age: _____
First Middle Last

Home Address: _____
Street City Zip Code

Home Telephone: (_____)_____

Parent/Guardian 1 Name: _____
First Last

Relationship to Child (e.g. Mother, Father, Guardian): _____

Day Telephone: (_____)_____ Evening Telephone: (_____)_____

Cell Telephone: (_____)_____ Pager: (_____)_____

Parent/Guardian 2 Name: _____
First Last

Relationship to Child (e.g. Mother, Father, Guardian): _____

Day Telephone: (_____)_____ Evening Telephone: (_____)_____

Cell Telephone: (_____)_____ Pager: (_____)_____

EMERGENCY CONTACTS

Emergency Contact Person (Other than Parent or Guardian): _____
First Last

Relationship: _____

Day Telephone: (_____)_____ Evening Telephone: (_____)_____

Cell Telephone: (_____)_____ Pager: (_____)_____

Emergency Contact Person (Other than Parent or Guardian): _____
First Last

Relationship: _____

Day Telephone: (_____)_____ Evening Telephone: (_____)_____

Cell Telephone: (_____)_____ Pager: (_____)_____

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MEDICAL PROFESSIONALS

Name of Child's Physician: _____ Phone: (____)_____

Name of Child's Dentist: _____ Phone: (____)_____

HMO/Medical Insurer/Health Plan: _____

Policy or Plan Number: _____ Phone: (____)_____

INFORMATION FOR MEDICAL TREATMENT

List all medications child is taking: _____

List child's allergies to medications, food, other: _____

_____

Please note **all** conditions for which the child is currently receiving treatment:

_____

List any additional, important, or useful medical or other information about your child:

_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of _____, and
(Child's full name)
that I am responsible for making decisions about medical and dental care for my child. I grant my authorization and consent for the Program employee or volunteer to administer general first aid treatment for any minor injuries or illnesses experienced by my child. If the injury or illness is life threatening or in need of emergency treatment, I authorize the employee or volunteer to summon any and all professional emergency personnel to attend, transport, and treat my child and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice under California's laws. By this Authorization, my child may receive emergency care, treatment, and services at the doctor's office, or at any California licensed hospital or emergency care facility. Further, I agree to fully pay all charges for such care.

I understand that I am giving this Authorization (a) in advance of any specific examination, diagnosis, treatment, or care that my child may need, and (b) so that medical professionals can give my child emergency medical care and treatment which, in the exercise of their best judgment, they may deem advisable for my child.

This Authorization will be valid, and will remain in effect, during my child's participation in Program activities and while my child receives emergency medical care.

This authorization is effective through: _____

Parent / Legal Guardian Signature: _____

Printed Name: _____

Date: _____

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AUTHORIZED ADULT RELEASE (PICK UP LIST) of authorized individuals who have permission to pick up your child from the Program. We will not release a child to anyone who is not listed here. Please include mother/father, and siblings or relatives over the age of 18.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Child's Name: _____

First Middle Last